

DRAWING ON THE NATURE OF EMPATHY
by
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ABSTRACT

My research investigated the impact of introducing structured drawing activities to staff of a mixed ethnicity hospital community in south-east London, to address the question of whether drawing was a useful tool in the practice of empathy. Empathy, 'putting oneself in the shoes of another' was examined critically through drawing as practice, conducted within the hospital environment. This research coincided with a period of major change for the hospital Trust, which had low staff and patient satisfaction and poor financial performance when the research began in autumn 2006. The long-term nature of my collaborative doctoral research enabled me to slowly expand the boundary of what was acceptable arts practice in a healthcare context, while ensuring that the 'dangerous' practice of empathy was worked through via art practice in such a way that these dangers were encountered, analysed and understood.

The research project focused on the benefits (and complications) of drawing within the hospital community, during a time of immense turmoil. Drawing was used to aid investigations, sustain the craft skills of medicine, explore emotions and thoughts, and ground and focus staff in empathic therapeutic interventions. These interventions allowed staff to slow down, play, analyse and reflect, creating a space within the context of the hospital, where the practice of empathy was reviewed. The work used dialogue between the dual practices of art and medicine to explore complex intersubjective communication.

The core practice, drawing, was embedded in a longitudinal study of drawing events based in the same hospitals at yearly intervals since 2007, so that a similar body of staff had the opportunity to participate in these collaborative events. Using cross-sectional surveys centred on the *Big Draw* (Campaign for Drawing, 2000) I set up a series of encounters including interactive drawing events, lectures, performances and exhibitions, and participated in drawing conferences within the Trust, galleries and art colleges nationally and in the USA. Smaller scale investigations of individual practice over the same period of time, in venues for both the visual arts and music, complemented the main studies and allowed a triangulation of theory, methodology and data, bringing a number of methods to bear upon the question of whether drawing was a useful tool in the practice of empathy in hospital environments.

At the core of my research is a definition of a practice of empathy based on my work in the research activities. The elucidation of a set of features, pertaining to the practice of empathy, has been defined by these events. My definition of empathy was constructed by building temporary collaborative communities during these events through which the dynamics of empathy were examined and its features analysed. In my research, art practice emerges as methodologically

important to the proper understanding of the problems, dangers and opportunities of empathy in clinical practice.

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ABBREVIATIONS:

CEO Chief Executive
CCW Camberwell, Chelsea and Wimbledon Graduate School
FIS The Future is Social
QEH Queen Elizabeth Hospital, Woolwich
QMH Queen Mary's Hospital, Sidcup, Bexley
PRUH Princess Royal University Hospital, Bromley
LGNT Lewisham and Greenwich NHS Trust
LPMDE London Postgraduate Medical and Dental Education
NHS National Health Service
RNUAL Research Network University of the Arts, London
SLHT South London Healthcare Trust
SSM Special Study Module
UAL University of the Arts, London
WHO World Health Organisation

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Introduction

The research investigated the impact of introducing structured drawing activities to staff of a mixed ethnicity hospital community in South–East London and questioned whether drawing was a useful tool in the practice of empathy.

My research addressed three questions:

Firstly, whether drawing could be used as a way of working out how to sustain and augment the craft skills of medicine and explore emotions and thoughts, within empathic therapeutic interventions during the throes of hospital mergers, disaggregation and re-mergers with resulting staff, public and political conflict. This was addressed in **Chapter Four**.

Secondly, whether drawing could shift the rhythms and responses of the staff by grounding and focusing them, when addressing anxieties through art practice. A subsidiary question was whether these practices produced some of the benefits of talking therapies, without using this technique on a one-to-one basis. This was addressed in **Chapter Five**.

Thirdly, whether I could entice empathic interactions at the meeting points of contemporary art and medicine and contribute to academic debate in both arenas. This was addressed in **Chapter Six**.

Drawing, as defined in this PhD, is creating a narrative with a simple tool held in the palm of the hand¹ (Gabriel, 1993) and includes making marks or writing with pencil, pen or brush and paper, making a sketch with tiny pieces of ceramic clay (*bocca*), or squirting a stream of alcohol gel, for rubbing on the hands (Godfrey, 1990). This definition keeps drawing within an aesthetic, technical and historical framework that was accessible to a wide range of individuals. Drawing was used to investigate the craft skills of medicine with staff, and explore emotions and thoughts, in empathic therapeutic interventions.

The research used the dual practices of art and medicine, working from the dual perspectives of an artist and clinician within the institutions I studied. On the basis of the research I conducted, I argued that medicine and healthcare have much to learn from an exchange with collaborative art practices. The research had three phases: an early phase when the parameters of the research were established; a second phase characterised by critical questioning; and a late experimental phase, when art addressed anxieties concerning how hospital staff could respond and adapt to change. During the final stages of the research, the greatest challenge for the staff was not so much doing the clinical

¹ A disabled participant using foot or mouth to enable them to draw would be welcome, as would anyone choosing to use an alternative simple strategy for holding a tool. The hand has been chosen for the definition as that is the part of the body practicing the craft skills of medicine, which is one of the objects of my study. Mechanical devices that copy the action of the hand may also be included, for example, Rebecca Horn's tool for drawing the bow across a cello (2005).

work as coping with the uncertainty that was present at every level of management throughout the evolving Trust.

In order to identify what was at stake in *Drawing on the Nature of Empathy*, Chapters One and Two contain a review of the field of enquiry, encompassing the differing approaches to empathy: psychoanalytic, psychological, neuroscientific and biosemiotic (the biology and philosophy of the language of signs). My experimental research practice was situated within this broad intellectual framework, as well as being contained within the field of Medical and Health Humanities. I tested the claim that visual art, the spoken word and performance (including music) could be used to embody the practice of empathy in medicine and health, to assist staff to understand and cope with the complex arena in which they worked. The research did not involve patients but I collaborated with a wide range of staff members of the hospital, whom I considered to be my colleagues.

My art practice, in the context of the doctoral research, drew on the work of the 1960s neo-concretist artist Lygia Clark, whose work moved from abstraction into a more therapeutic, socially engaged arena. Another visual arts practitioner significant for my research is Christine Borland, whose shows, *With Practice*, Newlyn Gallery, Penzance (2007), *Cast from Nature*, Camden Arts Centre (2011), *Divine Imperfect*, Piers Arts Centre, Orkney (2012a) and finally *Death Animations*, Baltic Centre for Contemporary Art, Gateshead (2012b) focused on medical issues and participation of both artists and medical students. Borland was shortlisted for the Turner prize in 1997 for her work about medicine and the body. She worked on a NESTA fellowship in art and medicine and has a long standing collaboration with artists and hospital clinicians and researchers in the art and medical institutions of Glasgow and Northumbria University.

During over seven years of research, I found that a number of practices helped me in the exploration of empathy through drawing in hospital situations. Sometimes the work involved lying down and drawing with both hands, eyes closed and at other times it was simply sitting down and talking. Thinking through the being of an animal, modelling *bocca* (small sketches), treating the *bocca* with bronze dust or gliding the bow of the cello over the strings to make loud rumbling sounds that resonated with the trundling waste bins, were all devices I used. These activities, including splenic palpation, had parallels with practices in the clinical environment. They were performance acts that fell within the bounds of art as well as medicine. They were elaborated in the thesis where I explained how I believed these works enabled me to explore gestures and hovering attention in the healthcare environment where I was embedded as artist and clinician.

Employing Empathy in a Hospital Environment

By the summer of 2007, before the first *Big Draw*² I began to have unease about the wisdom of aiming to 'release empathy' using a drawing framework that was rooted in psychoanalysis. Two or three experiences of clinical and visual art practice had made me concerned that using empathy 'freely' might be dangerous, especially in a clinical context such as in a hospital. A presentation at the Medical Humanities conference in Glasgow 2008 by Jane Macnaughton, Professor of Medical Humanities, subsequently published in the *Lancet* June 2009, articulated this anxiety quite explicitly and suggested the use of sympathy instead of empathy, as a safer option.

A different stance on empathy was taken by Robert Marshall, Consultant Histopathologist and Classicist, and Alan Bleakley, Professor of Medical Education and Psychologist, who looked at empathy from the perspective of pity and compassion, as shared by the Ancient Greeks and written about by Homer (Bleakley & Marshall, 2009). The long-term nature of my research enabled me to steer a course between these landmarks and slowly expand the boundary of what was acceptable arts practice in a healthcare context, while ensuring that the potentially dangerous aspects of evoking empathy using art were anticipated, encountered, analysed and understood. They become tolerable and may even be helpful. Art practice was thus posited as methodologically important to the proper understanding of the problems, dangers and opportunities of the practice of empathy in the context of health.

The research resonated with my experiences as a medical student. I arrived in London from the country in the 1970s and was exposed to the British Museum, Tate Gallery, dissection of the cadaver and the beating heart of an open-chested greyhound at medical school, yoga and other practices from the East, music played by fellow students and finally the encounter with the drama of human life in hospital medicine. The movements and articulations that were important to my understanding of empathy, were grounded in this time. With the help of my collaborators and participants, I developed the current project as an experienced artist and doctor. Together we moved in and out of an envelope of understanding, using the medium of drawing to allow our attention to hover at the interstices and boundaries of both practices.

Methodological framework

The methodological framework adopted for this study included action research, which combined both research and implementation. It is a participative research method that involved action and reflection with the teams and individuals who put the changes into practice (Somekh, 1995, Leitch & Day, 2000). Action research has its origin in the educational problem-solving approach of the 1940s in the USA. Its first well-known

² A structured drawing activity in the form of a corridor event which passers-by, mainly staff, are invited to join, held on an annual basis from 2007-2013 inclusive

exponent was Kurt Lewin (1890-1947), the social psychologist. Lewin (1946) described a circular process for action research that included planning, executing and fact-finding for evaluation. This research was intended to catalyse change in the setting under study. Action research has been used in industry, healthcare and education (Holloway, 1997).

In order to assess what the effects of my interventions were, the study had to be longitudinal, over a number of years, as healthcare environments tend to change slowly. However during the final stage of the research externally imposed changes happened rapidly, highlighted by national media, as South London Healthcare Trust, the most financially challenged Trust in England (Department of Health, 2013), became the subject of negative media publicity. Progress had to be deeply rooted and quick.

External political pressures produced changes that disrupted the research as well as the hospital. I responded by shifting my methodology to focus on my own practice, using it as an opportunity to express what I believed to be common thoughts and feelings through my own body. I used the therapeutically oriented practice developed by Lygia Clark in the sixties and seventies. This was germane because my own medical training began in the early seventies. The emphasis was on the process of healing.

I invited art practitioners and researchers from University of the Arts London to help me with my task and counter-balance the despondency that was at risk of overwhelming us, the staff. The benefit of longitudinal studies is that complex questions can be considered (Denscombe, 2003). I had been deeply involved with the Trust since the late eighties. This was an important consideration when undertaking action research in this setting, as I may not have been totally detached and impartial. The aim of the drawing investigations was to examine how the practice of clinical empathy was viewed differently, and possibly practised differently, following a greater engagement with drawing. The workshops, lectures and exhibitions were fully integrated with both the educational and the arts programmes of the Trust.

The work of theorists and practitioners within the field of enquiry was examined. The problem of empathy was explored using drawing, collaboration and psychoanalytic theory. The background to the research on empathy was the field of Medical and Health Humanities (art, literature, poetry, music and philosophy, used to aid medical practice and healthcare). The different ways we think and feel individually and in groups were examined through a particular drawing based art practice that was tracked over seven years; power relationships and changes were explored. The *Big Draw* events gave staff, from the chief executive and senior medical staff to the porters and cleaning staff, opportunities to draw and play with time, allowing the space to reflect and analyse. The

benefits of these practices were taken seriously by senior medical, nursing, education and managerial staff. It felt as if they were part of standard clinical practice.³

During this doctoral investigation I use my voices as both an artist and clinician (a medical microbiologist, working with almost every department in the Trust) to interrogate the problem. It is important to state that these experiments had the full support of the Chief Executives and the Special Administrator⁴ of the Trust, who were keen to see the impact of artistic endeavour in the field of clinical practice. Key announcements in the unfolding dialogue between the hospital staff, their managers and the Department of Health were marked by some of the concluding events in Chapter Six.

My practice within the Trust was part of a dialogue which included internal resistance. The voice of the artist, rather than the clinician, allowed me (and others) to examine the strange and often ambiguous situations we found ourselves in as a result of our hospital work. This was particularly pertinent when resources were scarce and the hospital merger disrupted the fabric of our lives. Working within a community that understood a practice-based approach and respected academic endeavour, had advantages. PhD research into collaboration and empathy was taken seriously, especially in the closing months of South London Healthcare Trust.

The aims and research question shifted during the project. My experience of thirteen or so NHS and art school mergers led me to expect that times would be tough and people would lose a sense of place and purpose. Informal in nature at the beginning, the pilot event took place at an extraordinary meeting of senior medical staff, drawing with cleansing fluid. It challenged the blind spots of staff at all levels of the Trust, using both direct and subtle dialogues. The weft and weave of these conversations developed into the basis of the art problem solving activities used in the research.

The research demonstrated that the practice of drawing enabled staff to work through what was and was not dangerous in the practice of empathy in a clinical context. Participants, including artists who helped me, were referred to by first name. This defined the community and acknowledged the work without betraying too much information.

³ Noted by Dr Chris Streather, Chief executive and Renal Physician, Senior Medical Staff Committee at QEH, September 2010.

⁴ Matthew Kershaw, Special Administrator, replaced the Chief Executive and the Board in July 2012. He has 'special powers' which enable him to enable changes to take place in the whole of the South-East Thames region, which should allow our Trust to extricate itself from its financial difficulties. I wrote in an email to the Arts Manager 7 August 12 'I talked to Matthew after the open meeting. He is just as enthusiastic as Chris was about the place of Arts in Hospitals...Matthew is totally up for our approach including the research work, hand cleansing, as well as all the exhibitions. He loved the Green Chain exhibition' (Chandler, 2012)

An outline of the chapters

In Chapter One, I described the field of Medical and Health Humanities; the arts and humanities as they are used to explore the field of medicine and to look at leading practitioners in the field, such as Christine Borland who worked in the realm of the anatomy of the body, and how it is considered in medicine, with particular reference to mortality, resuscitation and physical repair of the body.

Chapter Two critiqued the individual methodological framework for empathy, through a psychologically and psychoanalytically based practice on a one-to-one basis, examining the work of Anna Arago, Donald Winnicott and Daniel Stern in the therapeutic and academic arenas. Daniel Batson's social frameworks for empathy were explored and I finished with references to debates on empathy in aesthetics and biosemiotics.

In Chapter Three, I examined examples of socially engaged practice that contextualise my work, with particular reference to Grant Kester, Claire Bishop and Jeremy Deller's *Battle of Orgreave* and *Acid Brass*. I also made reference to the theoretical framework of Lygia Clark, whose work uses the body within a therapeutic arena. This account of the context of my research framed a discussion of: participation and collaboration, the objects that are made or used during shared work and the team-based approach. I looked at how to explore empathy in group work within a therapeutic arena. I located myself as an artist within socially engaged practice. Bishop's observation that this type of work is carefully and empathically integrated and managed was taken seriously.

Chapter Four introduced the methodology of action research that was approached through annual cycles of experimentation, reflection and change. It described the first phase exploring craft skills before the onset of political upheaval in the Trust and clarified my position as an artist researcher, who also worked as a clinician in the Trust. It was a methodological introduction to the pilot phase at Queen Elizabeth Hospital, Woolwich (QEH). It formed the basis of the more expanded and riskier experiments which built upon this bed of experience. This enabled the project to move forward, expanding the definitions of drawing and empathy, as the experiments built upon one another in a series of action research cycles.

Chapter Five documented how the Trust adopted a new structure as a result of the merger of three hospitals. I described the approach I adopted in the new South London Healthcare Trust (SLHT) in April 2009, which had an emphasis on working alongside managers and using more provocative, experimental drawing techniques that could also be practised more broadly within the Trust with the aim of grounding and focusing staff and helping them to adjust to change.

Chapter Six explored the consequences of participating in a collaborative experiment about the merger of the three art schools, Camberwell, Chelsea and Wimbledon (CCW),

and set the scene for even more open ended experiments in *The Future Is Social (FIS)*, *Flat Time House* with artist Sonia Boyce. The interface between medical practices and art was explored using an alter-ego, Wanda Klenz, who gave me the freedom to explore cleansing, double blind drawing and lying down to palpate spleens at multiple locations (including London and New York) leading up to the disaggregation of SLHT and the formation of Lewisham and Greenwich Healthcare Trust on 1st October 2013. These events crossed boundaries between art and medicine, encountering problems in the *FIS* workshops that were re-encountered in the Trust during the mergers and disaggregation.

Definitions of drawing and empathy as used in the thesis

Drawing

For the purposes of the *Big Draw* investigations, noted above, the term drawing is taken to mean the act of telling a story with a simple tool or material that fits in the palm of one's hand.

My definition is in tune with that of Gerlinde Gabriel who talks about the hand and the tool in *The Body of Drawing: Drawing by Sculptors*:

For the hand holding the pencil which makes the line of the drawing is also a form which cups itself into a container, suggesting a structure, a 'body', which begins to be the inside and outside of what is the material condition of sculpture (Gabriel, 1993, p 5).

Empathy

I began my research with the following definition: '...entering the private world of someone else and becoming thoroughly at home there' (Rogers, 1980, p 142). This was used in the instructions for the first *Big Draw* in 2007 and was also used in 2008 and 2009 for consistency. It was brief, used the concept of movement and suggested a complex space, which I felt was important. I have not used it in the textual analysis as I became uncomfortable with it. I found that Carl Rogers's psychotherapy and counselling framework lacked sufficient boundaries for use in a general hospital. He used techniques where identification, or even merger of identities, may take place, rather than the more subtle approach referred to below by Paula Heimann.

A definition of empathy by Gauss (2003) was written on a large paper scroll, on which participants could lie down and be drawn around, as part of a large interactive drawing in the first *Big Draw* event in 2007. It was dropped because of the confusing way it used sympathy to define empathy. It nevertheless remained relevant to my research as it employed the resonance between two strings on a musical instrument as a metaphor for empathy. I repeatedly used the cello in my events, as both an instrument and a metaphor for the patient. It gave rise to the use of cello (open strings, notes C, G, D, A) in an

improvised installation, to accompany the first presentation of the event (*Big Draw*, 2007), beginning a strand of investigation using cello on subsequent occasions.

The following phrase 'putting oneself in someone else's shoes' was used frequently. I found it helpful when introducing a talk.

We are inclined to attribute to other people - in a sense, to put into them - some of our own emotions and thoughts...By attributing part of our feelings to the other person, we understand their feelings, needs and satisfactions; in other words, we are putting ourselves into the other person's shoes. There are people who go so far in this direction that they lose themselves entirely in others and become incapable of objective judgement. (Klein 1959 pp 252-3)

Melanie Klein's phrase had the advantage of brevity and the suggestion that one *moved* around in someone else's world. However she sounded a note of caution, pointing out that one can become lost this way.

The rationale for an emphasis on a psychoanalytic view of empathy

Empathy was studied in a wide range of academic disciplines, as diverse as psychoanalysis, psychology, social neuroscience and literature, and they all described it using slightly different terminology, depending upon their individual disciplinary cultures. I left Batson's eight types of empathy (from the perspective of social neuroscience) until Chapter Two. I finish my introduction to the topic of empathy with the definition that fitted best with my practice as both an artist and doctor. Paula Heimann's description hovered between past and present and alluded to future change.

Heimann, a psychoanalyst and student of Melanie Klein, initially made the following observations, in 1949 at the Zurich Psycho-Analytic conference:

We know that the analyst needs an evenly hovering attention in order to follow the patient's free associations, and that this enables him to listen simultaneously on many levels. He has to perceive the manifest and latent meanings of his patient's words, the allusions and implications, the hints to former sessions, the references to childhood situations behind the description of current relationships, and so on. By listening in this manner the analyst avoids the danger of becoming preoccupied with any one theme and remains receptive for the significance of changes in themes and of the sequences and gaps in the patient's associations. (Heimann, 1950, p 82)

This complex definition was at the core of my discussion about empathy. Although it was defined for a psychoanalytic setting, it has all the important elements in it that pertain to

my research. It contains movement (hovering) and yet is also quiet and still (allowing the other person movement). It allows someone to talk, think and feel on different levels at the same time (if you can manage it). It contains space (gaps) for the other person to work with; in other words it does not make uncorroborated assumptions about what is going on or assume that the analyst has a wholesale emotional identification, which is impossible to ascertain correctly. At best it is partial identification, which is probably far more comfortable and less frightening for the patient. Eventually Paula Heimann broke away from Melanie Klein's group and became part of the Independent group of psychoanalysts (British Psychoanalytic Association, 2016).

Later I go on to talk about shifts in art practice; Heimann noted the importance of remaining 'receptive for the significance of changes in themes' (Heimann, 1950, p 82), which is a type of shift.

Action research

I also used the principles of action research (or collaborative enquiry), which helped to generate theories regarding social phenomena which are grounded in or derived from the systematic analysis of data (Denscombe, 2003), in order to understand the practice of empathy in our hospitals. I developed my practices using aesthetic, psychoanalytic, psychological, neuroscientific and biosemiotic evidence about empathy. These ideas are informed by contemporary art practice and include theoretical evidence from debates on relational aesthetics and 'dialogical' projects.

As this doctoral research about drawing occurred within a clinical community, which was a complex situation to examine, a mixed methodology including both quantitative and qualitative elements was used (Lingard, Albert & Levinson, 2008). Qualitative methodology alone was used for the first three *Big Draw* events (pilot phase) and some quantitative methodology added in the fourth, in order to examine the ideas in a more manageable way, enabling more qualitative work to be done at a later stage. This plural methodology helped the information to converge and produced greater insight than a single method.

The contribution to knowledge of this project

The intention of this research was to address a gap in the study of empathy in the field of medical and health humanities. The collaborative activity that this project was based upon employed an extended engagement with the practice of empathy in a hospital environment. Although there is a long history of collaboration between art and medical science, it is rare for an individual to practice for so long or in such depth in a hospital environment, holding senior clinical and educational roles, whilst also leading an engaged practice as a visual artist and researcher. The enquiry was performed in a systematic way, using careful longitudinal and cross sectional analysis, and presented as an arts

impact study that has the voice of the artist at its core. The art was presented to the full range of staff in the hospital from cleaner to consultant surgeon, from laboratory worker to senior manager, from ward assistant to Director of Nursing. A distinctive feature of this study is that it has utilised my professional experiences as a doctor, who learned about developing and maintaining the clinical practice of empathy, whilst also investigating the same arena as an artist.

The long duration of this research, practice-led for seven years, allowed two things to happen. Firstly, it enabled me to move from a more traditional drawing practice, with some sculpture, installation and performance, to an arena that was more therapeutically inclined and performance-led. The use of simple relational objects as a way of engaging participation helped me to have open conversations with my participants. Secondly, the organisation of the Trust in which the research was based changed significantly and repeatedly during the period of research. Many staff left and those who remained were tired and disillusioned; others resented being absorbed from neighbouring Trusts. This formed the perfect test bed for socially engaged practice where aesthetics and therapeutic practices went hand in hand. I wanted to return the Trust to a more stable rhythm. I used all that I knew in this arena to score my goals.

PART A: THE BACKGROUND OF MEDICAL AND HEALTH HUMANITIES, EMPATHY COLLABORATION, SOCIALLY ENGAGED PRACTICE AND DRAWING

Chapter One: The Field of Enquiry of Medical and Health Humanities

Summary of Chapter One

Chapter One describes the use of the humanities in understanding medicine. The work of artist Christine Borland is introduced in the context of the exploration of art practice in the interdisciplinary field of Medical and Health Humanities. Her work is described extensively alongside other artists who have made a significant contribution. Some of the important issues and characteristics are highlighted. Beyond visual art, the significance of spoken word, music and literature is also addressed, as telling stories about what is happening in disease is an important part of medical enquiry. The chapter begins with a discussion and clarification of the views of medical practitioners interested in issues of empathy, sympathy, compassion and pity. Borland's art practice is then considered in detail. Next, the chapter introduces questions regarding the existing and potential roles of empathy and drawing in medicine, and the use of traditional, collaborative and performance working methods. Finally, the chapter concludes by explaining the relevance of medical and health humanities for this research project, outlining how they informed the methodology and how specific artists influenced research practices.

The central question in Chapter One is:

Who are the key players in the theory and practice of empathy in a medical and health humanities context, and what approaches do they use and why?

This leads on to a second question: what relevance might these approaches have to the merger and disaggregation that took place during the course of the research, and how best can we address empathy problems in our hospitals? This question is implicit in this chapter and it is addressed further in subsequent chapters as a greater understanding of the field of enquiry evolved.

Concerns about sympathy and empathy in the medical arena

Medical and Health Humanities is an interdisciplinary field, including arts disciplines, that studies the social and cultural dimensions of medical knowledge. The debate on empathy within this arena has focused on two questions. Firstly, how should clinicians practise, with empathy, sympathy, or compassion? Secondly, if empathy is the way forward, then how is it to be practised? To address these questions in my research, I used the practices of drawing, performance and the making of small objects (*bocca*) in collaborations with hospital staff. Jane Macnaughton (2009), Professor of General Practice at Durham University, has stated in her paper *The Dangerous Practice of Empathy* in the *Lancet*:

I have suggested that true empathy derives from an experience of inter-subjectivity and this cannot be achieved in the doctor-patient relationship. We have a momentary mirroring of that patient's feeling within us, but what we maintain is sympathy (feeling for but not with the patient) and the need to respond. It is potentially dangerous and certainly unrealistic to suggest that we can really feel what someone else is feeling. It is dangerous because, outside the literary context, where we are allowed direct experience of what a fictional patient is feeling, we cannot gain direct access to what is going on in our patient's head... A doctor who responds to the patient's distress with "I understand how you feel" is likely, therefore, to be both resented and self deceiving. (Macnaughton, 2009, pp 1940-1)

Macnaughton is sounding a note of caution. Despite the inclusion of empathy in a systematised format in medical training and assessment (London Postgraduate Medical and Dental Education, 2014a) she opened the debate on whether we can and should achieve it. The traditional stance of the doctor was distanced and objective. Macnaughton draws heavily on literature, poetry and philosophy to make her point that it is only in literature and poetry that we really know what the other person is saying, as they express their innermost thoughts in words. Through this research, I have come to the conclusion that the act of drawing with someone enables you to have a better guess about what they are thinking and feeling, enabling riskier territory to be negotiated. In *Philosophy of the Flesh: the embodied mind and its challenge to western thought* (Lakoff and Johnson, 1999), sympathy is defined as a feeling that uses empathy to move us to seek the well-being of others. This suggests that sympathy may not be broad enough to work in a wide variety of situations. Lauren Wispe's distinguishes:

In empathy the self is the vehicle for understanding, and it never loses its identity. Sympathy, on the other hand, is concerned with communion rather than accuracy, and self-awareness is reduced rather than enhanced....In empathy one substitutes oneself for the other person; in sympathy one substitutes others for oneself. To know what something would be like for the other person is empathy. To know what it would be like to be that person is sympathy. In empathy one acts 'as if' one were the other person...The object of empathy is understanding. The object of sympathy is the other person's well-being. In sum, empathy is a way of knowing; sympathy is a way of relating. (Wispé, 1991, p 80)

The distinction between sympathy and empathy is examined further in Chapter Two. The rationale behind using the artist/participant relationship as a way to investigate models of the doctor/patient or colleague relationship is that, unlike the literary model, not everything is expressed in words and is instead constructed through shared practice. (Macnaughton, 2009).

Effective empathy is the attempt to put oneself, to some extent, in another person's shoes. If it is done in a way that is recognised by the self and the other as an imperfect, but also benign, form of communication, it leads to a non-intrusive compassion. On the other hand, it can become ineffective, and sometimes destructive, if it becomes intrusive, too inaccurate and either attempts to merge with the other or assumes an identity. A claim to feel your pain may be an imaging of the pain that is not accurate. This is likely to be unhelpful as a means of expressing compassion. Batson (2009), whose ideas on empathy are expanded in Chapter Two, reminds us that our personal distress, which may contribute to some of the effects noted above, is definitely not empathy.

Christine Borland's exhibitions, including *With Practice*

Christine Borland is a leading practitioner for art within the field of medical humanities. The depth, breadth and intensity of her work in this arena have not been matched by any other artist. Her practice covers issues such as ethics in anatomy, communication and surgery, within a wide range of media including sculpture, drawing and video (Jordanova, 2014). The exhibition *With Practice*, Newlyn Gallery in Penzance, by Borland (2007), was made in conjunction with Alan Bleakley, then Professor of Medical Education at the Peninsular Medical School. It featured installations based on collaborations with medical students, pathologists and other hospital staff. A description of the works in the exhibition

follows, enabling the reader to gauge the way that Borland handled her subject material, which included forensic aspects of the physicality of medicine. At a talk about the Newlyn show, Alan Bleakley (2007) made an important point about the 'difficulty and importance of tolerating ambiguity' within a medical sphere, which echoes Jane Macnaughton's point about the ambiguity of the patient's 'voice'.

Two of the installations in Newlyn were titled *ABCDE* and *simMan*:

The vestibule is white. There are five letters, capital letters along the corridor. Under each one is a list of instructions. Medical students follow the instructions in order to learn their communication skills. Christine Borland interviewed final year medical students, who recounted their attempts to improve their communication skills. These stories are not available as text or recordings played out in the gallery. In order to hear the story it is necessary for the gallery visitor to participate, by taking a stethoscope, which is hanging on a peg at the end of the corridor. In order to auscultate, or listen to the voices, the bell of the stethoscope must then be placed on the wall. Softly spoken words can be heard, as if they are inside the wall, or the body of the exhibition. The voices talk about misinterpretations. Either the patients fail to understand the student or the student fails to understand the patients.

The main lower space in Newlyn Gallery is in semi-darkness. The room is dominated by a huge video screen on which there is an image of a life-sized pink fleshed male mannequin, breathing. His body is half-covered with a white cotton sheet, loosely draped over his abdomen and lower limbs, excluding his feet, which are visible. He is illuminated from above. The surround is in darkness. He continues to breathe. The camera glides over his body, slowly scanning hands, nails, chest, face, eye, and back, down over the folds of the cloth, to his feet and toes.

The dummy continues to breathe, with moderate inspirations and longer slower expirations. Sometimes these speed up slightly and then drop back to their original rhythm. Eventually the mannequin stops breathing and the screen falls into complete darkness.

As her contribution to *Taking the Body Seriously*, at the Association of Medical Humanities Conference, Durham, Borland showed the video *simBaby* (2009):

The screen image is a flesh coloured dummy baby, uncovered. The room is in semi-darkness. The body of the baby is in the room and he is breathing. At first the breath is smooth and regular with short inspiration and longer, slower expiration. Gradually, the camera scans the body of the baby from tiny finger nails, to hand, to arm, down the body to the feet and toes, which are perfectly formed.

The breathing increases in frequency, becomes more laboured and a slight wheeze develops. Breath becomes irregular with slight gasping sounds. A blue light appears between the lips of the baby. It is the colour of blue stained glass in a church.

The breathing slows and the regular inspiration and expiration resume. The screen falls into darkness.



Figure 1. *SimBaby* video, Christine Borland (2009)

The ventilation of the doll is mechanical with repeatable rhythms. A good doctor may have an automatic empathic response that is attuned to the slightest change in the rhythm of the breath. Noticing the quality of the breathing is not just a noting of the increase or decrease in the movement but includes an appreciation of the whole body, which the breath inhabits. The dummy cannot teach us this; in order to understand the breath, we need to observe the real as well as the accurate, but artificial, mechanical doll.

Christine Borland presented *simWoman* (2010) at the conference on *Humanities at the cutting edge: conversations between surgery, pathology, the humanities and the arts*. Association for Medical Humanities, Truro, Cornwall.

The screen shows a female figure in darkness, draped with a white sheet which covers her lower body, below the waist. Her form is in the light. Her face is very familiar, very human. Her eyes are closed as if in sleep. She is breathing with short inspirations and longer slower expirations. From time to time the breathing becomes a little faster, and



Figure 2. *SimWoman* video, Christine Borland (2010)

then slows again to the previous rate. The flesh of the hands and arms is soft, with slight irregularities and imperfections, in contrast to the smooth plastic skin of *SimMan* and *SimBaby*. Her arms rest gently on the sheets. Her palms face down and she has long slender fingers, which lie together. As the breasts lift with each inspiration the internal mechanism of the dummy is revealed a little. Eventually the breathing stops and the screen goes dark.

Christine Borland (2010) felt that *SimWoman* needed to come into being, beside her two counterparts *SimMan* and *SimBaby*. The medical students she worked with at Glasgow University considered the *SimFamily* to be functional puppets, providing demonstrations of emergency situations they were likely to face. Borland felt that *SimWoman* should also be

represented, to complete the family, so she dismantled *SimMan* and cast her own body parts for face, breasts, hands and feet.

Borland (2008) arranged an exhibition of contemporary work at the Medical Humanities Conference in Glasgow, which included *AAA-AAA* video by Marina Abramovic/Ulay (1978)

‘We are facing each other, both producing a continuous vocal sound. We slowly build up tension, our faces coming closer together until we are screaming into each other’s open mouths,’ Abramovic describes. (Gordon, 2008, p 2)

The action is in keeping with the artist’s emphasis on endurance art. A medical colleague who watched alongside me says, ‘I can’t stand this any longer’. She leaves. Art historian Rebecca Gordon, writes in the exhibition guide, ‘Does this lead to understanding or miscommunication? Indeed, can such raw primitive emotion yield communication?’ (Gordon, 2008, p 2). The experience of watching, alongside a medical humanities colleague, suggested that in order for a dialogue between doctor and patient or artist and participant/viewer to occur, the initiator of the activity needs to engage them throughout. Too intense a confrontation could lead to distancing of the viewer as a result of their personal distress. Rebecca Gordon’s response to her own question may be helpful here:

‘The enlightenment sought to supplant primitive emotion with reason, which is presumably the model followed by the medical students who are taught in (the communication suite) to restrain their natural instincts in favour of taught behaviour’ (Gordon, 2008, p 2).

Talking about her work with medical students, Borland (2009) said that she felt that opportunities for participation in her workshops were a ‘time for reflection’. She emphasised the ‘packed’ nature of the medical curriculum. At the following conference in Truro, Cornwall (2010) she reiterated this statement, adding her own personal reflections about being at the bedside of someone who was dying. These stories demonstrated a subtle shift in Borland’s matter of fact attitude to her work.

In describing her 1997 exhibition *The Dead Teach the Living*, which exposed white plastic copies of clay, dried and plaster heads, exhibited on narrow white plinths, from the medical faculty of the University of Munster, Germany, where Professors were involved in the study of racial hygiene and eugenics between the 1920s and the 1950s. Borland said:

The method of their reproduction has been as 'hands-off' and devoid of artistic interpretation as possible, produced almost completely by computer-generated techniques gaining a little distance from the overtly emotive originals in the anatomy collection, thereby inviting curiosity and interaction (Borland, 2006, p 78).

This hands-off approach, over a decade ago, is very different from the more tender approach to *SimWoman*. In Borland's catalogue *Preserves* from her exhibition at the Fruitmarket Gallery, Edinburgh she claims:

Being in a scientific or medical situation you just always remind yourself that you are an artist in that situation and, without meaning to sound callous, that you take what you need and you stop where it suits you. Often I stop at places which are irrational.' (Richardson, 2006, p 150)

The inclusion of *SimWoman* where the artist casts from her own body is a step on from this work. Has Borland moved from a position of sympathy to one of empathy and, if so, what can we learn from this work?

Borland gave us a reading of art practice in a medical humanities context that allowed us to understand the possibilities and pitfalls of working in this way. She emphasised the ambiguity of life in contrast to the pragmatic medical way of working and explored the misinterpretation of language. This suggested the way that culture may be interpreted or diagnosed, in medical parlance. Gesture was minimal in her practice allowing space for ambiguity in interpretation.

Ancient Greece: the relevance of Homer's *Iliad* in the contemporary debate about empathy in Medical Humanities

Psychologist Alan Bleakley, who was Professor of Medical Education at the Peninsular Medical School organised the Medical Humanities Conference, Cornwall, in the summer of 2010, wrote about the aesthetics of medicine, and examined the way that the understanding was teased out. The conference was a cornucopia of science, performance, simulation, film, poetry and music. Robert Marshall presented an analysis that moved on from his article *The death of Hector: pity in Homer, empathy in medical education*, which he wrote with Alan Bleakley in the Journal of Medical Humanities (2009)

There they tease apart the affective and cognitive strands of empathy, a twentieth century concept, in order to link them back to the 2000 year old archetypal scripts¹. The telling of stories is an important part of medicine². By taking us back to Homer, one of the first 'writers' of stories in Europe, who drew on long, oral traditions of story-telling and poetry, they showed us empathy as it was first recorded.

'Reckless one,
my Hector – your own fiery courage will destroy you!
Have you no pity for him, our helpless son? Or me,
and the destiny which weighs me down, your widow... (Homer, 6.482-85)³

Marshall takes us back to the very first 'clinics' at places like Epidauros⁴, where narrative, visual and healing arts were practised together.

In his conference presentation Marshall elaborates different translations of the poems and draws parallels with different ways of presenting a patient's story. Marshall talks about the type of virtuosity he thinks Homer is describing, which he feels is relevant to the 'quest for empathy in medical practice'. 'Virtuosity as a highly focused or concentrated activity combining physical prowess (skill) with a wisdom of the body (*metis*) that is best translated as 'adaptability', and an art of timing or exploiting opportunity (*kairos*). This

¹ 'archetypal scripts' (Bleakley and Marshall, 2009, P8) can inform doctors trying to make good clinical judgements. They claim that doctors know the likely outcome of their patient's illness and so are in situations which are similar to those of the ancient audience, watching a scene from Homer's poetry, written between the 8th and 7th century BC. It is believed that the texts were written by Homer, who may have included large amounts of traditional oral stories, well known to the audience. These stories were told over and over. The audience feel pity at the tragic turn of events, and 'empathises' with the characters, in a well-rehearsed and controlled fashion.

² The use of a poetic line of thought was evident in participant in the first Big Draw where there was a series of activities to choose from giving the event a rhythm. Some participants used poetry or song to express ideas about what they were making. One medical student participant in a Special Study Module for Arts in Health (2008) wrote a new poem, prose and re-explored old poems in order to tell or retell her medical stories and personal experiences.

³ Robert Fagles translation (Fagles, R, 1990)

⁴ The sanctuary of Asklepios, the god of medicine, developed out of the cult of Apollo, between the 6th and the 4th Century BC, as the official cult of the city state of Epidauros, in the Peloponnesus. Here the shrine and the theatre are at the heart of a complex of temples and hospital buildings. The site provides valuable insights into the healing cults of Greek and Roman times (Unesco, 2016)

combination goes well beyond mere competence, turning sport into performance art. It is the field of play that is the *agon* of communication in medical practice, excellence might better be termed virtuosity, where virtuosity is a combination of skill (in reading and responding to cues) adaptability and the art of timing'. The authors call for a return to the grounding of empathy in the senses, reading empathy as a verb, rather than a noun, so that it is 'context-specific, as act or performance, rather than personality condition'. This foray into the drama of empathy goes beyond the sensitive and accurate sympathy that Jane Macnaughton is attempting to define. The fundamental question seems to be; can empathy be useful rather than dangerous in this expanded and complex field that the authors sketch out. Empathy needs to be practised in the contest. It is also the prize of that contest as it is useful when tensions run high, such as when unravelling mergers reach fever pitch.

The Homeric warrior, the skilled athlete and the finely tuned doctor all respond to signals in their own bodies, the questions they ask and the responses and bodily signals of others synthesising the subtle information they read. One result of this, for the doctor and poet is an opportunity to empathise with the other. In going back to these very old sources one incorporates some of the earliest attempts to grapple with the problem. Also one of the participants in the very first Big Draw worked as an attendant in the British Museum and later took me round the Greek and Roman galleries. Her vivid and contemporary descriptions (Chapter Four) brought to life stories of the gods I had loved since childhood; the gods sometimes invincible, sometimes having all too human frailties. This kept the flame of the ancient alive and it was later fanned by an invitation to participate in Grayson Perry's UAL event at the British Museum as part of *The Tomb of the Unknown Craftsman* exhibition (Chapter Six), when he described how works in the British Museum had underpinned his practice, and also used the objects directly and indirectly in the generation of his exhibits. I concurred. Those ancient relics, often of ritual significance, especially if they were tiny enough to fit in the palm of the hand, had a resonance for me and I guessed that objects we were to make in the hospital that echoed some of these objects would also echo empathic practice from ancient times.

Beginning in the winter of 2010 Christine Borland (2011) recast an original plaster cast of *From Nature*. The flayed body of a subject was laid on a plinth, in a pose reminiscent of Michaelangelo's *Pieta*. The sculpture was attributed to Sir John Goodsir, a nineteenth century Edinburgh surgeon, and it was recast cast in Glasgow Sculpture Studios, in a series of public castings that culminated in the creation of a new work, displayed in the main gallery. As the work progressed a record of the process was shown on projection screens in a specially created gallery amphitheatre. Two casts of the body were then shown in the exhibition *Cast From Nature*, Camden Arts Centre, May 2011. My description follows:

The two casts were separated from one another by a curtain of plaster which hung dramatically between the two end walls such that one had to duck under the ends to pass from one side to the other, a traversing of the liminal space between life and death. A thin space, symbolised by the two forms, which float on their welded metal supports, separated from the original plinth and each other. One form rested back as the other appeared to float upwards, inverted so that the rough inner surface of the cast was exposed, reminiscent of the casts of Medardo Rosso (2007), a contemporary of Rodin, giving the works an abstract and elusive quality.

Rosso's acts of casting and recasting fragments of his older works allowed him to visit the past, present and future and hover between them in a way that is analogous to Paula Heimann's description of counter-transference, the process of empathy. The act of casting and recasting is also fundamental to the way that empathy can be explored using action research which revisits situations again and again, logging and adjusting the process in response to the artist and participants in the research (Rosso, 2007).



Figure 3. *Cast From Nature* , Christine Borland (2011)

Drawing and empathy in medicine: traditional and collaborative works

In her introduction to *The Quick and the Dead*, Deanna Petherbridge says ‘...many of the drawings and objects made by artists and anatomists have been regarded in the 20th century as too disturbing for a non-medical audience, and have been stored out of sight in museum collections and libraries.’ (Petherbridge, 1997 p 7). The subject of my own investigation is within the contemporary hospital, not the pre-enlightenment scenes of public dissection.

A more useful approach for a hospital environment was the description of the open-ended nature of drawing given by Michael Craig-Martin in *Drawing the Line*. The characteristics of drawing include ‘spontaneity, creative speculation, experimentation, directness, simplicity, abbreviation, expressiveness, immediacy, personal vision, technical diversity, modesty of means, rawness, fragmentation, discontinuity, unfinishedness, and open-endedness. These have always been the characteristics of drawing’ (Craig-Martin, 1991, p 10). These attributes of drawing, I argue, can be used to explore concepts and problems in medical practice, including the practice of empathy.

Petherbridge, in the *Primacy of Drawing*, writing about what she called drawing the future, included a section on tropes of dysgraphia (Petherbridge, 2010). She described Cy Twombly's practice:

...where drawing and painting media are combined, is a performative dance around assertion, revelation and concealment: he equally fetishes the actions of laying down, cancelling out and erasure and hints of ideas to arrive at apparently nonchalant *non-bravura* statements that aim at a poetics of subjectivity (Petherbridge, 2010, p 418).

Twombly's drawings had the quality I was searching for by the end of the research, when the act of lying down became both relaxation and protest. Much of what we had achieved was being cancelled out and I felt that a poetic approach might be helpful.

Suzy Willson, Honorary non-clinical Senior Lecturer at the Royal London Hospital organised a Tate Modern conference about the *Medical Gaze: Empathy and Detachment*, with the artists Bobby Baker and Kira O'Reilly and psychiatrist Kamdaleep Bhui (Willson, 2008).

Bobby Baker, performance artist, has used drawing extensively (2009). At the conference she talked about her drawings, made over a ten-year period, in a treatment centre where she had up to 400 admissions for the management of her borderline personality disorder, arthritic knees and breast cancer. Baker retained a huge sense of humour in her presentations. At times during this project her approach felt too extreme to include but as time went on and the merger tightened its grip on our NHS Trust, her drawings, with their vivid images of family, managers and therapists took on greater relevance.

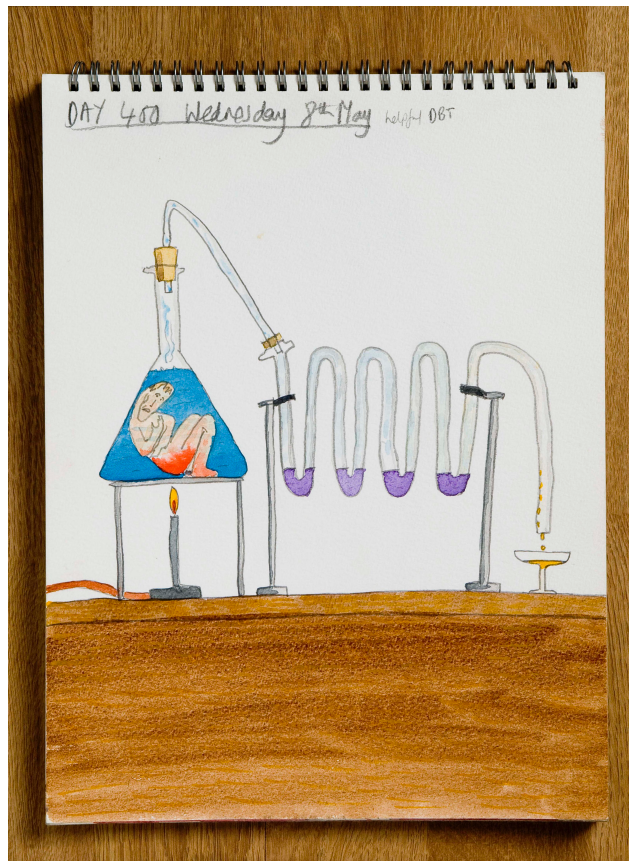


Figure 4. Bobby Baker's Diary Drawings: Mental Illness and Me 1997–2008 © Bobby Baker and Andrew Whittuck 2009

More images of these artists' work are shown in Chapter Five as they were presented to medical staff as part of a Grand Round education session. Kira O'Reilly worked in biotechnology laboratories in Australia (2004), where her detached scientific experiences and technical training in the laboratory enabled her to use tissue-cultures, suspended on spider silk.



Figure 5. Laboratory: Kira O'Reilly, whose red coat engaged staff

Some laboratory staff, fascinated by O'Reilly's exploration, were surprised when she insisted on wearing a red laboratory coat, rather than the usual white one, when working with her cultures, demonstrating how a small visual change can engage staff (2015). O'Reilly developed an interest in animals, laboratory or otherwise, expressing this by embracing a dead pig at *Home*, Laura Godfrey Isaac's performance site (O'Reilly, 2005), or dancing with a pig at Newlyn Gallery, Penzance. (O'Reilly, 2006). Images of her red coat and metaphorically dancing pig were shown in one of my events in 2009 (Chapter Five). These activities of empathy and detachment are also applied to her own body. She draws by repeatedly incising her own body so that it is covered with a tracery of tiny scars, including this as an inter-active event, when she invites participants to cut her, noting their expressions of concern that they do not wish to hurt her (O'Reilly, 2006).

Kamdaleep Bhui, Professor of Cultural Psychiatry & Epidemiology at the Institute of Preventative Medicine, at Barts & The London School of Medicine & Dentistry, spoke of young doctors' tendency to become less empathic during their training. This is to help them cope with the intense emotions they experience in response to death, a sense of responsibility and feelings of powerlessness about the nature of disease. (Bhui, 2008)

The artwork of Baker and O'Reilly confronts these tendencies, encouraging doctors to express and maintain a wide range of thoughts and feelings that will feed their craft skills in empathy (Willson, 2008).

Art can help doctors to develop the skills required to touch, to listen, to see, and to hear, encouraging students to challenge, subvert and question institutional hierarchies, to ask the question, 'Who am I looking at and how am I looking at them?' Artists can provide students with valuable insights into human experience and difference, challenging them to think seriously about the aesthetics of medicine, helping to restore a sense of dignity to a profession that feels somewhat beleaguered. (Willson, 2006, p 16)

Wanderers through a sea of fog was the first film and video installation selected for the glass entrance hall of the recently relocated Royal College of Psychiatrists. The selection of work addresses the question posed above by Suzy Willson: 'Who am I looking at and how am I looking at them?' The video installation curated by David Gryn included David Blandy, Samuel Levack and Jennifer Lewandowski and Terry Smith. The videos were displayed on a vertical triple video screen hung within a three tier open space, lit by a chandelier from the old college building. In Smith's video *About Face* the camera focused on eyes, nose, mouth or panned from full face to profile and from man to woman, playing a child-like game, substituting one part of a face for another (Gryn, 2014).

In David Blandy's *Wanderers through a sea of fog*, a hand drawn sprite, a digital version of artist Blandy, walked through Caspar David Friedrich's sublime landscape, the video camera tracking his progress from one side to the other. On another of the triple screens he stood almost motionless, moving his head from front to side. Here his pose was dejected, hands in pockets, shoulders hunched. The artist drew our attention to the popular culture that surrounds us (Gryn, 2014).

The third video work to be displayed seamlessly in the entrance hall screen is by artists Samuel Levack and Jennifer Lewandowski. Gryn writes '...shot over the course of a few days prior to Glastonbury Festival 2013, on a ley-line running through the vale of Avalon, *Solstice* was an exploration of the histories, landscape and atmosphere of what has come before and what will be.' (Gryn, 2014, p 2). The artist sums up with a quotation from Long: 'Above all else memory and imagination rule the psychic landscape' (Long, 2014, p 6). Gryn states that the college has decided:

...to prioritise the inclusion of contemporary art in this way signals both a recognition of psychiatry's importance to visual and aesthetic culture, as

well as the importance of the institution to work with a wide array of partners from across the cultural spectrum' (Gryn, 2014, p 1).

Having surveyed the breadth of partners for the Medical Humanities I want to return to the work of theatre director Suzy Willson, who has developed a training programme *Performing Medicine*, for medical students and junior doctors, using arts and performance methodologies to teach skills that relate to empathy and are essential to clinical practice as a doctor. This work has relevance to my engagement with these skills in my clinical and art practices. Willson says:

One of the principles of *Performing Medicine* is a belief that a poetic and social understanding of the body can sit beside a clinical one without compromising either and instead enriching both (Willson, 2014, P 31).

Important benefits from Willson's work (2011) include learning to reduce 'performance anxiety', act like a doctor, become more aware of others, whatever their background, bring oneself into focus and improve communication skills. This justifies her approach having a place within the broader medical curriculum.



Figure 6. *'Performing Medicine' I*, photo by Benedict Johnson (2015)



Figure 7. *'Performing Medicine' II*, photo by Benedict Johnson (2015)

Reflections on the roles of art and Medical and Health Humanities

During the research I used a critical medical humanities approach within a broad approach to health and well-being. The importance of the former approach is that it:

...allows us to see meaning in illness and provides a point of resistance to biomedical science. It also draws on the avant-garde in arts and humanities to provide deep critical impact. Such an approach is political and practical, as well as aesthetic and ethical, where it provides a potential democratising force for medical culture...as an aesthetics of resistance (Bleakley, 2014a, p 24).

The approaches of participation and socially engaged practice, taking place largely within the art gallery and corridors of the hospital, allowed me to democratise the project whilst also picking up the rumbles of resistance to change, tantalising the institutions of art and medicine, with both humour and optimism. The dance of staff back and forth, as they traversed the corridors, opened up opportunities to look at the work within a broader picture of health, as sketched out by Paul Crawford in his work on Health Humanities (Crawford, 2015).

Within the arena Christine Borland highlighted lying down and breathing and recasting the sculpture of a cadaver, Kira O'Reilly danced with a deceased pig, emphasising our membership of the animal kingdom and the importance science places on experimentation with animal tissues. Bobby Baker drew about the disturbing things that happened to her, and performed with a pea, emphasising the role of gesture within nature.

Some of this work is also collaborative in its practice. Borland involved medical students' voices in her sound piece, O'Reilly worked with laboratory staff when she studied the practice of tissue culture to make her lace images, and Bobby Baker collaborated with many individuals dressed as massive round green peas in her event.

Suzy Willson brought a theatre director's pragmatic approach to the drama of medicine and coached medical students in practical approaches to dealing with the self, patients, colleagues and the problems of medical practice. The overwhelming sense of presence of the body, whether it is representing life, death or the transition between, that surfaces in Borland's videos and casts of the body, resonated deeply with my preoccupation with these states. In contrast, the joyous hand movements of Willson's participants, shown in *Performing Medicine* capture the energy, delicacy and intimacy of the caring hand gesture. It is my interest in these states that led to the development of the work in Chapter Six, with splenic palpation and hand cleansing, which addresses my third research question about how art and medicine can enter a useful dialogue.

The work in the Royal College of Psychiatrists concentrates on some of the senses of confusion, loss, and mystery that occur in disturbed states of mind. It is of relevance in this research as some of these feelings beset members of staff during the organisational challenges. This leads on to Chapter Two, where I focus on the background to the empathic process in practice.

Chapter Two: Methodological Frameworks of Empathy

Whoever wanders somewhere in the night
without purpose
counsels me

Rilke's Confession, Danny Abse (2013)

Summary of Chapter Two

Chapter Two examines empathy in the literature. It aims to identify an attention that hovers with another (Heimann, 1950) in order to understand their feelings and thoughts and thus to work out how to relieve their suffering. I began with an historical point of view, followed by an examination of empathy in social neuroscience, psychoanalysis, then psychology and philosophy, from a biological perspective.

I explored empathy through the psychoanalytic approach of Anna Aragno (2008a) and Daniel Stern (1985). Both use a combination of psychological experiments and psychoanalytic experience to explore what is going on in human interaction. I included experimental evidence from animals such as monkeys (primates) as there are some similarities between their higher functions and those of human beings.

I commented on the social neuroscience research reviewed by Daniel Batson (2009), who looked at how empathy is used in different social situations; I gave examples of these in order to explore the ways that empathy works. Again, I included work about animals as I am interested in their symbolic roles as well as experimental data produced from working with them. I considered some of the more complex thought patterns that use imagination on a conscious level in order to empathise. This entailed looking at the language that has been used to describe this complex phenomenon over the last three hundred years or so. I also focus on the aesthetic use of the term empathy early in the twentieth century and on the beginning of scientific exploration of the phenomenon in the laboratory environment.

The key questions in Chapter Two are, firstly, how you know what someone else is thinking and feeling? You can know from trying to work it out either using a Theory of Mind (ToM) or from some sort of trying out (simulation method). Secondly, what do you

do about it when (and, more importantly, if) you know? Can you help the other person and, if so, how? Might you hinder them?

In order to link these two areas of questioning to the following experimental ones, I looked at psychological types of empathy and developed examples from the arts, literature and my own practices. These examples were then used as unlocking devices, in order to consider issues, objects, drawings and other works that emerged during the experimental phases.

What is empathy?

A series of articles about an academic exchange on empathy, introduced by psychoanalyst Bonnie Litowitz (2008) in *Journal of the American Psychoanalytic Association*, has been used as an important touchstone in my research. The series included contributions from three psychoanalysts, a neuroscientist and a philosopher with an interest in neuroscience from a biological perspective.

I chose to approach empathy, using this academic exchange, through the work of psychoanalyst (and ex prima-ballerina) Anna Aragno (2008a), within the context of both psychoanalysis and the neuroscientific advances of Vittorio Gallese (2008). Gallese discovered the mirror-neurone network in macaque monkeys, which is thought to be useful in the practice of empathy. Siegfried Zepf and Sebastian Hartman (2008), two German psychoanalysts, examined empathy using projective identification, transference and counter-transference, which they considered to be fundamental in the establishment of empathy between individuals. There was considerable debate about Zepf and Hartman's threefold approach. Some experts, including Zepf and Hartman (2008), questioned the value of new developments in neuroscience and child psychology, mainly on the grounds that this 'laboratory' style work was too fragmented to reflect the full complexity of relationships in the analyst's consulting room. My approach included using drawing events embedded within the hospital where I worked as a doctor; this meant that my relationship with many of my participants and collaborators was based on something much deeper than that established in the brief time of a drawing workshop. It also involved discussions on the wards (day and night) and in the canteen, car park, committees, corridors and education centre. Thus my research analysed a mixture of

verbal and non-verbal information. I also discussed the linguistic and pre-linguistic investigations of the biosemiotician Donald Favareau (2008). Favareau works between the disciplines of semiotics in philosophy and biology. The emphasis of his interest is on signalling as a way of making meaning.

Empathy is not therapy but the presence of empathy is essential to the clinical setting, in order to understand not only the patient but also any other, in both the consulting room and the hospital. Aragno (2008a) believes that empathy begins with the interpersonal communication between the infant and primary carer during the first few months of life. She wrote that most practitioners used the explanation of a trial identification, which is partial or temporary, experienced as a voluntary and transient regressive merger, leading to a suggestion of the other's emotional experience. She emphasised the importance of perceptual and emotional attunement (Aragno, 2008a), using the analyst as if he or she is an instrument in the therapy (Freud, 1912) where resonance, authenticity and empathy are fundamental for psychoanalytic listening. Freud recommended only reflecting back what is shown in the analysis.

Freud (1921) and Kohut (1959) agreed that empathy was important in establishing trust and forming an alliance, penetrating the inner states of another person and facilitating regression and redevelopment. In contrast Buie (1981) favoured insight over empathy, which was viewed as unscientific, potentially misleading and an unreliable source of information, as Jane Macnaughton (2009) pointed out in the *Dangerous Practice of Empathy*.

The boundaries of empathy

From a social neuroscience perspective, empathy that is to be socially beneficial is thought to require three distinct skills: the ability to share the other person's feelings; the cognitive ability to intuit what the other person is thinking and feeling; and an intention to respond compassionately to that person's distress (Nickerson, Butler & Carlin, 2009). Macnaughton's paper (2009) discussed the dangers of this approach if one is unsure what the other person is feeling. She counselled that it is pragmatic to be tentative about one's conclusions.

Niyi Awofeso replied to Macnaughton's *Lancet* article on empathy saying:

...it is difficult to gain a complete understanding of what a patient is feeling or experiencing. However, in many instances, an essential difference between a competent doctor and a good one is that the latter is better able to use her or his ability to sense and understand a patient's feelings to work through the patient's beliefs, relationships, and stresses to facilitate a speedy recovery...the art of empathic understanding in a physician-patient setting involves accomplishing acts of 'witnessing' a patient's distress and establishing a therapeutic alliance. (Awofeso, 2009, p 683)

The complex picture of empathy

In the *Social Neuroscience of Empathy* Daniel Batson (2009) wrote a review of the eight main types of empathy found in the literature. I found his approach useful, because it offered many different ways of gaining access to someone else's thoughts and feelings and it is consistent with Paula Heimann's 'hovering attention' (1950), which also suggests some sort of moving between viewpoints in order to empathise with the other. Batson was not only concerned with *how* we find out, but also what leads us to 'respond with sensitivity and care to the suffering of another' (Batson, 2009, p9).

Concept One: Knowing another person's internal state, including his or her thoughts and feelings.

Synonyms: 'cognitive empathy' (Zahn-Waxler, Robinson & Emde, 1992), 'empathic accuracy' (Ickes, 1993)

The problem is that of knowing what someone else is feeling. Checking that the knowledge is accurate is an important part of this approach and reflects some of the concerns Macnaughton (2009) raises. So, for example, if a junior doctor wants to discuss the management of a patient who deteriorated during the night, I would have listened to what they said but I would have also paid careful attention to how they said it - their tone, intensity and hesitations - in an attempt to be accurate with my empathic assessment of their concerns for the patient. I have discovered through experience that the rhythm, stress and intonation within their speech, its prosody, often gave me as much information as the patient's laboratory test results. Aziz-Zadeh, Sheng & Gheytanchi (2010) noted

that individuals who perceive prosody are also better at empathising emotionally, suggesting that both the junior doctors and I may have perceived important information about the patient, using this phenomenon. This leads on to the second concept.

Concept Two: Adopting the posture or matching the neural responses of an observed other

Synonyms: 'motor mimicry' (Hoffman, 2000), 'imitation' (Lipps, 1903) & (Titchner, 1909)

Adopting the posture was used to good effect in the play of Michael Morpurgo's *Warhorse*, staged at the National Theatre (2007). Life-size wicker horses were inhabited by puppeteers. Susannah Clapp commented on the expressive nature of the animal puppets, who moved freely, animated from inside by the actors, who were strangely visible through the curved bamboo frames. Each horse was controlled by two puppeteers, one inside moving or shivering the body and the other steering the head, twitching the ears or rolling the eyes (Clapp, 2007). As a result of this one knew what the horse was thinking and feeling not only from the dialogue his rider had with the silent beast (for these wicker puppets were ridden during the performance), but also from the animal's personified gestures.

Concept Three: Coming to feel as one imagines another person feels

Synonym: Not only emotion matching but also emotion 'catching' or 'emotional contagion' (Hatfield, Cacioppo & Rapson, 1994)

The problem with this approach is that the meaning that is 'caught' in emotional contagion may be very different from the original meaning. For example, is it competition for food or emotional contagion when baby birds tweet loudly together in a nest or babies all cry at the same time in a nursery?

Concept Four: Intuiting or projecting oneself into another's situation

Synonyms: '*empathie*' (Lipps, 1903) 'empathy' (Titchner, 1909), 'aesthetic empathy' (Wispé, 1968)

Batson (2009) felt that this process included the creative process used by a painter or writer imagining what it would be like to be some specific person or some inanimate object. The work produced may resonate for another; it may follow a certain trace in their mind, in tune with their thinking. For example, when *Two Forms (Divided Circle)* by Barbara Hepworth (1969) was still in Dulwich Park, I stood between the two halves. The space between was just a perfect size for an average sized woman like myself. There was something about being in that space that made me feel as if I was experiencing resonance with Hepworth; not only physically occupying a space she had occupied, but emotionally too.

Concept Five: Imagining how another is thinking and feeling

Synonyms: 'imagine other' perspective (Batson, 1991), 'psychological empathy' (Wispé, 1986)

This represents sensitivity to the way the other is affected by the situation. One might imagine the responses of a friend or partner who is developing dementia; thinking of what is important to them in their lives is a way of guiding responses. This involves sensitivity to the other person's character and how that character might respond to new situations. In this instance, it may be helpful to consider the responses of the person with dementia through the interpretation of another, for example using Judi Dench's portrayal of the difficulties experienced by philosopher and novelist, Iris Murdoch, as her Alzheimer's dementia progressed, in the film *Iris* (2001). This is a way of helping to conceptualise interpersonal situations that are difficult.

When I practised as a microbiologist I used to put myself in the situation of a single celled bacterium, causing sepsis in a patient, and imagine which part of the body I, the bacterium, would be able to target with my pathological mechanisms, in order to help me, the microbiologist, find the source of the infection. It used to amuse me that occasionally when I encountered one or two of my surgical colleagues as I visited one of their sick patients, they teased me as if I were a bacterium, such as *Staphylococcus aureus*.

Concept Six: Imagining how one would think and feel in the other's place

Synonyms: 'changing places in fancy' (Smith, 1759/1853), 'perspective taking' or 'decentring' (Piaget, 1953)

This is an interpersonal, rather than aesthetic, context and so it differs from just looking at the situation of another person or an inanimate object in an aesthetic way.

Stotland (1969) called this an imagine-self perspective to distinguish it from the imagine-other perspective of Concept Five. These two perspectives may be confusing but research by Batson (2009) suggests that they are different.

If I were to imagine myself in the situation of a friend whose partner has cancer, I would still be aware of the differences between us. In this way of imagining I foreground my own responses to the scenario whereas in the previous example I foreground what I imagine the responses of the other would be. There is a subtle distinction. The doctor or medical student who made a football for the flesh coloured *bocca* figure to play with, in my one of my Big Draw events (Chapter Four) might have been doing the latter.

Concept Seven: Feeling distress at witnessing another person's suffering

Synonym: 'empathic distress' (Hoffman, 1981) or 'personal distress' (Batson, 1991)

This is useful in that it may motivate one to do something about the suffering, such as giving to charity to enable others to relieve the suffering of Ebola virus victims. However, if it is too distressing, one might walk away.

To return to the example of a friend with cancer – if I was sufficiently distressed by the thought of it I might try to help my friend, whereas if I was excessively distressed I might withdraw from the friendship.

Concept Eight: Feeling for another person who is suffering

Synonyms: Other-oriented emotion 'sympathetic distress' (Hoffman, 1981), 'sympathy' (Wispé, 1986)

This is also called 'pity' or 'compassion' (Batson, 2009), which is interesting from an historical point of view as they are probably describing something that later would be called empathy. The nursing profession declared that compassion was one of the six important ways nurses should improve their performance. The December 2012 report *Compassion in practice: nursing, midwifery and care staff; our vision and strategy* was followed a couple of months later by the *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry* (2013), in the wake of a national outcry about NHS performance. This was relevant because Trust staff had been criticised for their lack of compassion and kindness.

A participant at *Big Draw* (2009) said 'empathy is acknowledging another person's feelings/experiences and trying to understand their thoughts/feelings' which seemed to fit into this description of feeling for another. This is also what Macnaughton (2009) talked about when she suggested the use of sympathy instead of empathy.

Empathy at the beginning of the twentieth century

E. G. Titchener (1909), an English student of Wundt, coined the translation empathy in 1910, using the Greek root *pathos* for feeling and the prefix *em* for the word 'in'. Wundt was credited with the development of psychology after he emigrated to the United States, where he set up the first psychology laboratory at Cornell University (Wispé, 1987). Empathy was developed as an aesthetic theory in the work of Theodore Lipps (1903), who wrote *The Science of Aesthetics*, where he described the experience of empathy as seeking to break down the distinction between subjective feelings and objective reality. It was an experience often described in pantheistic terms. Empathy was thought of as a mode of intense perceptual absorption in which lines and forms were experienced by the subject as specific motor sensations and were the catalyst for a vitalisation of the imagination.

Lauren Wispé (1987) claimed that empathy should be distinguished from sympathy (German *Mitgefühl*), which referred to a shared experience. 'In empathy the self is the vehicle for understanding, and it never loses its identity. Sympathy, on the other hand, is more concerned with communion' (Wispé, 1987, p 80). Empathy is a way of working out one's relations to the objective world by objectifying oneself (Wispé, 1987). In Theodor

Lipps' accounts (1903), the perception of an emotional gesture in another being, directly activates the same emotion in the perceiver, without any intervening labelling, associative, or cognitive perspective-taking processes. Lipps (1903) said that his way of living was to empathise into life. Struggling, achieving some things and not others and contemplating one's inner self are what life is about when one empathises. He was thinking of empathy as an activity in which he used energy. For him the activity was a voluntary motion that was also an expression of his will.

The idea of endeavour in motion is also talked about by Bleakley & Marshall (2009) in their text on Homer's *Iliad* and the practice of empathy in medicine.

Art and traditional aesthetics on empathy

Works of art are incapable of experiencing human feelings. How, then, can they express them? Robert Vischer proposed an answer in *Das optische Formgefühl* or *Empathy, Form and Space* (Vischer, 1873). The explanation, he said, must lie in some unconscious process of the person who views these forms. The viewer must endow the objects with their vital content by an involuntary act of transference, of which he is not at the time aware. The concept of 'feeling into,' or *einfühlung* was proposed. Vischer (1873) elaborated it as a psychological theory of art which asserted that the dynamics of the normal relations in an art work suggest muscular and emotional attitudes. The viewing subject experiences those feelings as qualities of the object. Aesthetic pleasure may thus be explained as objectified self-enjoyment in which subject and object are fused.

Art historian James Elkins wrote in *The Object Stares Back* (1996), commenting upon Vischer's approach to paintings and exemplifying his own reaction to them:

Vischer ... was interested in the way that [paintings] can communicate feelings without needing language to do so. Pictures of the body can elicit thoughts about the body, and they can also provoke physical reactions in *my* body. If I look at Medusa's body for too long, I may get a twinge of discomfort. Paintings of spindly figures might give me a crick in my neck, and Michaelangelo can exhaust me as if I've been to the health club. (Elkins, 1996, p 138)

An academic exchange on empathy: psychoanalysis, neuroscience and biosemiotics

Aragno (2008a) claims that empathy is not a special mode of perception. She believes it originates in undifferentiated *infant* synaesthesia, or unity of the senses, when the foundations for emotional perception, attachment and social-affiliation bonding are also laid down. Synaesthesia means having a set of sensory experiences in another mode, such as hearing music and seeing it simultaneously in colour. Aragno's discussion of this subject related to the mother mediating infant experience in one mode by translating it into another mode, as discussed by Stern (1985).

The to-and-fro nature of the connections between global expressions of primary emotions and the attachment-behaviour networks share deep roots. Differentiation of detail and content is poor in this system as it begins early, being present in a primitive form shortly after birth, as emotional contagion.

Emotional contagion is a package of awareness; facial, vocal and postural expression, neurophysiological and autonomic nervous system activity and instrumental behaviour. It contrasts with conscious empathic processes or mediated empathy, which have their roots in appraisal and cognition, used within the clinical situation for therapeutic benefit. It was the to-and-fro nature of these connections in the hospital community that enriched the thesis investigations.

In order to talk about counter-transference, it is necessary to mention first the phenomenon of transference, which is complex. In *The Language of Psycho-Analysis* by J. Laplanche and J-B Pontalis transference is defined as follows:

For psychoanalysis, a process of actualisation of unconscious wishes. Transference uses specific objects and operates in the framework of a specific relationship established with these objects. Its context *par excellence* is the analytic situation. In the transference, infantile prototypes re-emerge and are experienced with a strong sense of immediacy. As a rule what psychoanalysts mean by the unqualified use of the term 'transference' is '*transference during treatment.*' Classically, the transference is acknowledged to be the terrain on which all the basic problems of a given analysis play themselves out: the establishment, modalities, interpretation and resolution of the transference are in fact what define the cure. (Laplanche & Pontalis, 1967, p 455)

So, *transference* denotes a shift onto a psychoanalyst or object standing in his or her place; of a person's feelings, desires and modes of relating, which have been formerly organised or experienced in connection with someone from the patient's past, in whom they are highly invested, such as their parents. It is used by psychoanalysts to help them understand what is going on for their patients. It refers to the tendency to treat another not as they really are, but as if they have aspects of very early relationships. The psychoanalytic situation tends to evoke transference effects strongly.

Counter-transference forms one of the elements of empathy in the clinical situation. Zepf & Hartmann (2008) describe some of the important processes in counter-transference, including the analyst's conscious and unconscious reactions to the patient's transference, noted by Sandler, Holder & Dare (1970). This is consistent with the definition of counter-transference found in Laplanche and J-B Pontalis (1967) and is a description that many analysts feel comfortable with. Sandler, Holder & Dare's (1970) review also noted that the counter-transference may be a manifestation of the analyst's blind spots. In contrast Aragno does not mention the phenomenon of counter-transference. She stated that she believes 'in the value of integrating linguistic and semiotic principles to understand psychoanalytic phenomena' (Aragno, 2008a, p 726).

Jane Macnaughton's anxieties about empathic accuracy arise in relation to the territory of blind spots and it is here that one has to be most careful. She pointed out the need to beware of the crass approach 'I understand how you feel' (Macnaughton, 2009, p 1940). She also referred to the transitory nature of her identification with the patient. She talked about being briefly sad with a seriously ill patient one moment, and then laughing over coffee with a colleague the next. It appears that Macnaughton is concerned that her reading of the patient's internal state may be insubstantial; and may cause difficulties in the treatment if she goes beyond the safe boundaries of sympathy.

One of the clearest distinctions I have found between empathy and sympathy is in Suzanne Keen's book *Empathy and the Novel* (2007) where she takes her perspective from both psychology and philosophy and describes the two phenomena as follows:

Empathy I feel what you feel *or I feel your pain*

Sympathy I feel a supportive emotion about your feelings *or I feel pity for your pain.*

(Keen, 2007, p 5)

Keen qualifies her distinction between sympathy and empathy: ‘...the spontaneous, responsive sharing of an appropriate feeling as *empathy* and the more complex differentiated feeling as *sympathy*’ (Keen, 2007, p 4). In my experience I found that there is a tendency for those using experimental and therapeutic approaches to use the expression empathy, whilst literary approaches use the term sympathy.

The question of the relationship of empathy to sympathy is difficult. The terms are used differently by a variety of authorities, for example the psychoanalytic text *The Language of Psychoanalysis* (Laplanche & Pontalis, 1967) comes from a Freudian perspective and lists both terms in the index, whereas *A Dictionary of Kleinian Thought* uses a Kleinian framework, does not mention sympathy and refers to empathy as ‘one of those benign forms of projective identification’ used in order to understand experiences of the other person (Hinshelwood, 1989, p 291).

The earliest positive use of counter-transference in the psychoanalytic situation was described by Paula Heimann (1950). She referred to a mental muscular movement (hovering attention) that was also quiet and still (allowing the other person movement). It allowed thinking and feeling on different levels at the same time. It contained space (gaps) for the other person to work with and was consistent with the attentive stance, ‘(evenly) suspended or poised’, as recommended by Freud (Laplanche & Pontalis, 1967, p 43).

Heimann’s description of ‘hovering attention’ in order to ‘avoid the danger of becoming preoccupied with any one theme’ and ‘remaining receptive for the significance of changes in themes’ draws attention to the delicate and sensitive nature of the inter-subjective experience with the patient. Her approach (Heimann, 1950, p 82) paved the way for a more multi-dimensional arena of dialogue between doctor and patient.

My art practice, in its ‘hospital as studio’ approach, used a ‘hovering attention’, moving to and fro between layers of meaning and ‘primitive’ impulses, whilst I tried to make sense of

situations in the clinical environment, that were peculiar to my work. I began to realise that this was also useful when, in my role as a medical microbiology consultant, I used to talk to junior doctors out of hours. One knows the types of errors and omissions they are likely to make, but one does not know enough about each one of them or their actual situation at that moment in time. Hovering attentively, whilst they constructed a scenario, often enabled a fuller picture to be established and a better clinical suggestion to be made in response. I listened as much to what they said about themselves as heard what they said about the other, thereby second guessing what sort of error they might make. For example, a relatively junior doctor might over emphasise the importance of a series of numerical results, whereas a more experienced doctor would have the confidence to give more weight to clinical observations.

Psychologist and psychoanalyst Daniel Stern (1985) referred to the 'evoked companions' in the context of repeated experiences with the same individual, such that the memory of the relationship with that individual subtly changed with each subsequent interaction between the two. The evoked companion is a retrievable internal representation that can be activated by current interactive experiences. The memory or representation functions at the core of the individual, reinforcing the sense of self. Stern (1985) claims the bringing forth or activation of the memory contains the intensity of the first experience. It can be called upon when an historically similar episode occurs. An evoked companion is not a companion in the sense of a comrade but in the sense of a particular instance of one who accompanies another. The companion, which functions as prototype, can be updated in the light of new interactive experience (Stern, 1998).

Stein-Bråten (2007), a social psychologist from Bergen and colleague of Daniel Stern, explained the concept of evoked companions, or prototypes, as if a child were talking to him or herself about an experience that became embedded flexibly within their psyche, whilst in the presence of the person with whom they generated the memory (or someone very like them). This complex scenario allows the child to subtly update the memory and move on, as in an editing process.

The evoked companions never disappear and they work across four different developmental senses of self: emergent, core, subjective and finally verbal. These

stages are similar to the description of empathy by Daniel Stern, who compared empathy with attunement (Stern, 1985, p 145). Attunement is fairly automatic as long as there is awareness. Empathy is different, and has four distinct, probably sequential processes, which Stern described in his book *The Interpersonal Life of the Infant* (1985). These include: resonance of feeling state, the abstraction of empathic knowledge from the experience of emotional resonance, the integration of empathic knowledge into an empathic response and transient role identification. The initial stage of empathy does not require cognition but the latter stages do, which is why he used the term attunement instead. Stern (1985) felt that attunement was a way of automatically recasting an experience that resonated with an individual into another mode of expression.

The four stages of infant empathy, described below by Hoffman (Schaffer, 1996), have equivalence with Stern's description of empathy stages:

In the first year, global empathy is present and children may echo the emotions they witness: laughter with laughter or tears with tears. The emotions are not yet yoked to other responses; they are automatic, not voluntary, and are global (so the responses may be to any of the five senses).

From the second year, egocentric empathy develops and children may actively offer their help in an uncomfortable situation. The kind of help they offer is what they themselves would find supportive and in that sense it is egocentric. The achievement is in knowing that a comforting response is required and in making an empathic effort to provide that response.

In the third year, role-taking skills emerge and children become aware that other people's feelings can differ from their own, so that their responses to the distress may become better linked to the other person's needs as they are developing empathy for the other's feelings.

By late childhood or early adolescence children become aware that others' feelings may be complicated by a longer-lasting life situation, not just the present. Empathy may also

be found with respect to entire groups of people, who might be poor or oppressed in some way. Their empathic response may then transcend immediate experience.

Zepf & Hartmann discuss empathy, identification and projective processes. They quote Schwaber who says that empathy and empathic understanding are the 'antithesis of projection' (Schwaber, 1981, p 126). Laplanche & Pontalis describe projection as the 'operation whereby qualities, feelings, wishes or even "objects", which the subject refuses to recognise or rejects in himself, are expelled from the self and located in another person or thing' (1967, p 349). They use a simple example to help clarify. This also makes clear the difference between projection and empathy:

Even the simple projection of a state of tension or a diffused suffering onto one bodily organ allows it to be localised and its true source misapprehended (Laplanche & Pontalis, 1967, p 354-5).

Ogden noted that empathy occurs 'within the context of the dialectic of being and not-being the other' in which one plays with 'the idea of being the other whilst knowing that one is not' (Ogden, 1985, p 138). This seems to me to come closest to what I believe is happening as an active empathic process.

From a psychoanalytic perspective, Annie Reich described something similar, which she thought was counter-transference:

Firstly the analyst becomes the object of the patient's libidinal and or aggressive strivings (or the defence against them). Secondly in a special transient way the analyst identifies with the patient and in this way participates in the patient's feelings. Thirdly he recognises these feelings and instinctual strivings as belonging to the patient (i.e. he again becomes detached from the patient after having acquired knowledge about the nature of the patient through something that went on in himself). (Reich, 1960, p 391)

In many accounts transient transference identification occurs, an approach which belongs to the tradition of Freud (1914), as part of the counter-transference. If the processes are working well and the analyst glides into an identification and then effortlessly glides off again, as Jeffrey Mermelstein (1998) claimed in his writing on easy listening, then there is no problem.

However, if the identification or counter-transference has any 'sticking points', there is a sense of disconnection within the analysis, and the analyst is left acting-out or defensive. If attunement were perfect, it would be intolerable for the patient and probably the analyst too. The counter-transference needs to be good enough, in the way described by Winnicott (1953). The mismatches are as informative as the matches, providing that both sides continue to move easily in and out of an envelope of understanding. If the analyst adopts a rigid view that the patient does not grasp, then it becomes defensive.

Arlow (1985) described two types of counter-transference, one of which is empathic and conducive to therapy and the other which disturbs the analytic therapy, that he named counter-transference neurosis.

Empathic understanding sometimes signifies an understanding based on the analyst's capacity to use his or her counter-transference reactions as a means of acquiring knowledge about another person's psychic life. The analyst might aspire not only to feel together with his patient on the basis of individually different, though structurally homologous, scenes but also to understand the patient's internal frame of reference, which might still be unknown to the patient himself (Zepf and Hartman, 2008).

A neuroscientific and philosophical approach to the subject of empathy

Anna Aragno looked at the neuro-scientific evidence to support her way of understanding empathy. Mirror neurones were demonstrated in macaque monkeys by Vittorio Gallese, a neuroscientist from the University of Palma, Italy. These are brain cells that discharge or fire when the monkey performs goal-related actions, like grasping an object. These cells also fire when the monkey watches another monkey (or human) grasping an object. Similar systems were also found in patients with sub-cortical lesions or strokes. Observers noted that when stroke patients tried to use their paralysed hands to copy a gesture of grasping performed by another, the patients (and also people without strokes, who were a control group for the experiment) had an activation of neurones in the mirror neurone area - and that this activation occurred both in those patients who were able to grasp and in those attempting, but failing, to grasp. What is particularly characteristic is

that the same circuits fire whether an activity is carried out or merely perceived, in both humans and monkeys (Gallese, 2006).

Vittorio Gallese found that Broca's area was not only involved in speech control but also in prelinguistic analysis of the behaviour of others, by-passing representational, cognitive and linguistic systems. Recognition of the perceived action, state or emotion goes straight to the sensori-motor matching state in the viewer. Gallese (2008) thought of this instantaneous, unmediated understanding as embodied action simulation. He conceived of two types of empathy: one unmediated by conscious thought and the other deliberate and used clinically, requiring the ability to think about one's own thinking, in other words, metacognition. The empathic response is fed by perceptual, auditory and sensori-emotive cues as well as by linguistic structures which respond interpretively. Gallese hypothesised that the development of the neural circuits involved in mirroring were necessary for human social cognitive skills. Although these are possible mechanisms it is important to stress that this remains a speculative model.

Phenomenologist Maurice Merleau-Ponty described an interconnectedness of gesture: 'it is as if the other person's intention inhabited my body and mine his' (Merleau-Ponty, 1945, p 185). Gallese commented that '...these words clearly anticipate the "embodied cognition" take on intersubjectivity promoted by contemporary research' (Gallese, 2008, p 775).

Gallese noted that we have the capacity to 'experientially share the meaning of actions, intentions, feelings and emotions with others, thus grounding our identification with and connectedness to others [so that]... before being mind-readers, we are fundamentally behaviour-readers' (Gallese, 2008, p 775).

He continues 'We-ness and intersubjectivity ontologically ground the human condition, in which reciprocity foundationally defines human existence' (Gallese, 2008, p 776). Gallese agrees with Levine, who observed that transference and counter-transference can be viewed as 'two sides of the same analytic coin' (Levine, 1994, p 669). These comments are consistent with the understanding that 'resonance "from unconscious to unconscious" constitutes the only authentic psychoanalytic form of communication' (Laplanche & Pontalis, 1967, p 93).

Donald Favareau (2008) works between semiotics (the language of signs) in philosophy and the discipline of biology. He is interested in signalling as a way of making of meaning, which may be of use in the unravelling of empathy within a psychoanalytic context. The use of signs allows us to produce a spoken language and use written text.

Semiotics is fundamental to animal life, whether the signs are produced by immune cells, song birds, or animals using the sense of scent to identify and communicate with one another. The mating patterns of mammals or the fight for survival are all patterns of communication that rely heavily upon signs for camouflage or identification. The biosemiotician studies the chemo-electrical messages between brain cells or the coding and decoding of genetic material, DNA and RNA, between bacteria and parasites.

All codings rely upon a complex system of substitution relationships that are reliably associated with one another and are repeatable, so that a consistent exchange relationship is constructed. Sign usage is an ancient language that has been built up and naturally selected in a 'survival of the fittest' way. It predates symbol use, which is a culturally mediated form of communication, constructed on the basis of a complex net of signs.

Abstract human thought represents the greatest semiotic freedom, where even the opposite of what is observed can be represented, communicated and developed. This requires the ability to understand and perform metacognition, as noted above and below.

Concepts or symbols can become common currency in the public domain. Then the conditions for feed-back loops between icons, for example animal smells and their reliable associations in courtship rituals, are fulfilled. Eventually symbols can be augmented so that culturally mediated understandings of the world are developed and redeveloped by individuals, pairs and groups interacting with one another. In the world of human culture, ideas are freely exchanged and new iconic material can be incorporated into these associations, generating richer symbolic links.

Favareau points out that there are two types of experience that are important to us, either the I, the subject of my own experience, or the me, the object of other people's experience

(Favareau, 2008). Both states are experienced symbolically and, often, simultaneously. In examining the relationship between the self and the other, he suggests that our capacity to understand others, and put ourselves in their shoes, or empathise with them, depends not only on mental and linguistic abilities but also on an ability to identify with them because we share many actions, sensations and emotions. These vary from pre-verbal interactions, based upon mirroring, to complex understandings, manifest by abstract thought. At the moment of reflection an individual can form a mental representation of a mental representation of the other, so that a mature person can think about their thinking process in relation to the other, an action which is known as metacognition (Fonargy, 2004). This capacity also allows an individual to appraise and re-order memories (Main, 1991).

Aragno (2008a) stresses the importance of this dialogue between the disciplines of psychoanalysis, neuroscience and biosemiotics, marrying studies of the mind (psychoanalysis) with studies of the brain (neuroscience) and the framework or science of the meanings of biological signals and signs (biosemiotics).

Empathy in the Experimental Phases

Aragno, Gallese and Favareau discuss empathy from different perspectives but all three are concerned with the exchange of meaning between individual creatures using a language of signification, whether verbal, tonal or gestural. It is the integration of this broad range of knowledge that produces the greatest understanding of the practice of empathy. Important intuition from this approach should improve the insights gained from the practice of psychoanalysis. Aragno concluded her interrogation of empathy (Aragno, 2008b) from the fields of psychoanalysis, neuroscience and biosemiotics by pointing out that this broad framework widens the field of empathic processes and marries the concepts of the mind with the study of the brain, both of which are relevant to psychoanalytic knowledge.

This chapter has shown that empathy or 'putting oneself in the shoes of another' is a complex concept that belongs within the disciplines of psychology, social neuroscience, psychoanalysis, art, literature and biosemiotics. The importance of the practice of

empathy is that it allows individuals to form some sort of understanding of the other's state of mind: of the things that the other might be thinking and feeling.

In semantic terms the science (or knowledge) of the meaning of the words is important for tracing the history of the debates. The understandings of empathy (often prefaced with a descriptive term such as clinical) and sympathy, have shifted, merged and disaggregated during the last three hundred years. This happened particularly in the twentieth century, when society was changing, psychology laboratories were developed, the practice of psychoanalysis was being established and neuroscience research was introduced. 'Compassion' has recently been taken up by the NHS and 'pity' has stayed a little used term, often restricted to the Enlightenment and translations of ancient Greek.

A responsible healthcare worker or researcher should be able to think carefully about empathic practice and use it beneficially in clinical situations, enabling trust to be formed between individuals, no matter where they work or which term, of those noted above, they use to inform their thoughts, feelings, actions and gestures. This was the hub of my research.

My practice, as outlined in Chapter Four, began using global empathy - childlike and emotionally contagious - introducing staff to playing with coloured balls and modelling tiny figures, human and animal, within the context of a safe haven (or net) of protection.

In Chapter Five, I describe how, when the environmental context began to change and the new hospital Trust was formed, I used an egocentric empathy concentrating on the practices I felt were most comforting: modelling the figures, drawing with pencil and coloured pens, lying on the floor to draw and using the cello, not only as a metaphor for the body but also as a sounding device in its own right. I included hand washing as a drawing practice (when two surfaces rub together and leave a memory).

In Chapter Six, I show how, when confusion about the organisational changes was beginning to reach its height, I used empathy for another's feelings, extending the practices into the wards and departments, where my colleagues in the hospital were practising the craft skills of medicine in increasingly difficult clinical situations. We tried a gel dance for hand-washing and I used splenic palpation to ameliorate anger and

melancholy. In the final stages of the research, when the Trust was failing and there were plans to disaggregate, I used empathy for another's life condition. My colleagues no longer had time or energy for anything other than the briefest participations, glimpses and glances, tossing a comment to me as I sat drawing in the gallery or pausing for a very brief chat.

What was striking was how these time shifts influenced the fundamental relationship between individuals. The events that occurred during the formation, disaggregation and transformation of the hospital Trusts also produced *shifts* of terminology (as the Trusts changed their names) and understanding. The practice of empathy is fundamental to the cohesion of any organisation. It was vital to understand this concept for the planning, execution and proliferation of the three experimental phases of the research that follow.

Chapter Three: Methodological frameworks for collective empathy in participation, collaboration, performance and use of the object.

There was often a tender humour in the way the living body emerged from the protocols of the sculptural and the theatrical.
(Guy Brett 1998 pp 202-3)

Summary of Chapter Three

The aim of this chapter is to clarify the practices and processes that led artists to use socially engaged or participatory practice over the last twenty to thirty years, drawing on art made and critiqued during some of the major political upheavals of the twentieth century. This way of practising as an artist often emerged at times of unrest, change, revolution and transformation. These practices have provided a framework for my work in both art and medicine, at Queen Elizabeth Hospital, Woolwich, where the hospital became my studio (which helped me to practice as a good doctor), University of the Arts London and other collaborating institutions. The key questions in Chapter Three are:

Which of the main players in historical socially engaged practice are relevant to my work? Secondly, how are objects made, used or referenced, within socially engaged practice, in ways that might be useful in my work? Thirdly, what does socially engaged practice have to offer in terms of aesthetics, empathy and therapeutic approach that may be relevant to the problems faced by the individuals and community of the Trust, so that I can locate and contextualise my work in a defined field?

Three key texts by Hal Foster, Claire Bishop and Jessica Morgan establish many of the key terms for current socially engaged or participatory practice. These debates draw on the rich field of anthropology, highlighted twenty years ago by Hal Foster (1996) in his important essay *The Artist as Ethnographer*. This way of working with real life issues, through a practice that requires a carefully engineered engagement with societal factors, is critiqued

by Claire Bishop in her book *Artificial Hells* (2012). Bishop looks back at these developments from a twenty-first century perspective. A third text, *Common Wealth* by Jessica Morgan (2003), elaborates the earliest empathic social contract, discussed by Thomas Hobbes in his book *Leviathan* (1651). Morgan stresses the importance of the gift system of exchange, which underpins this social way of working.

Marcel Mauss' *The Gift* (1925) discussed how the gift economy was culturally organised. His anthropological study, translated into English in 1954, reflected the importance of the gift of goods or services as a method of exchange. In many societies, a gift is considered to be a formalised exchange, valuable as a way to augment bonds within society. An object or service may be given and in return the receiver is expected to give goods or services of the same or greater value. As the value of the return increases, a note of competition may creep in, thus raising the stakes.

Mauss' text describes real situations from an anthropological perspective. He investigated a diverse range of social systems in a systematic observation of the practices of others. This ethnographic description of peoples and cultures, customs and habits looks at mutual differences with respect to the system of exchange.

Jacques Derrida, in *Given Time*, said:

'One could go so far as to say that a work as monumental as Marcel Mauss's *The Gift* speaks of everything but the gift: it deals with economy, exchange, contract (do et des), it speaks of raising the stakes, sacrifice, gift and countergift—in short, everything that in the thing itself impels the gift and the annulment of the gift.' Derrida (1992, p24)

Mauss (1925) assumed that the gift is a form of exchange, a return for a former gift. According to Pyyhtinen (2014) he failed to distinguish the gift from debt. There remains an interesting question about where and how the gift may fall down in this cyclical system.

Mary Douglas, an anthropologist, in her introduction to the 1990 version of Mauss' book,

talks about the gift in ancient systems of law and economy beyond Polynesia, where the original work was done. Mauss (1925) demonstrated that with Roman, Germanic and other Indo-European laws the basic principles of the gift system are there. Gift cycles engage people in permanent commitments that show the dominant institutions and there are no free gifts.

Talking about Mauss' description of gift systems Douglas (1990) notes that the system of exchange is simple, involving a continuous cycle of exchange within and between generations. Gifts have to be returned with an item or service of equal or greater value. This competitive system reinforces a system of status which stabilises the members of the groups and forms the society:

This cyclical exchange of gifts or services was relevant to the hospital mergers, where staff were thrust into new situations with unfamiliar people. They were expected to function as before, with respect to clinical practice. New systems of management would be required and societal patterns of exchange, distilled using art practice and objects, might help them to accommodate the changes.

The Other, Psychoanalytic Theory and the Making of Art

In *The Social Turn*, the first chapter of *Artificial Hells*, Claire Bishop (2012) refers to Jaques Lacan's insistence that it is more ethical for the artist to challenge unconscious needs, desires and resistances, rather than restricting the arena to the exploration of the Big Other (society, family, law and expected normal behaviour). This way of working allows artists to broaden their horizons within collaborative practice, to examine difficult situations and to speculate upon cultural significance. Artists, considered within a field of practice that is social and analytical, would thus be more aware of the dangers of too narrow a focus on the individual.

Rather than responding to bland exhortations to make art that will improve society, the most

exciting and uplifting collaborative projects occur when artists reflect freely upon a combination of their own curiosity and social conscience. This desire for authenticity, rather than social conformity, allows artists to explore both their own and society's resistance to examining difficult events. Situations are stage-managed to allow the collaborating artists access to the feelings and thoughts of others, in response to the projects they have conjured. Such processes allow the protagonists to work through intersubjective practices and gain access to complicated social relationships. Bishop (2012) claims that political Utopian ideals can be scrutinised, whilst exploring the needs of society and codes of morality, in response to disruption in the world arena. It is important to note that within participatory and socially engaged art there is often an emphasis on ethical responsibility that tends to exclude aesthetic issues and theories, so that artists, their participants and the spectators of their work may not be inclined to discuss perverse and paradoxical situations.

I go on to explore the work of Lygia Clark, who collaborated with Helio Oiticica. Clark used simple domestic objects in enactments with people (including some with schizophrenia), who reported therapeutic benefit. From the view of practice her work was deeply embedded in the community rather than taking its perspective primarily from aesthetics (Brett, 1998).

Collaborative practices: different points of view

My research deliberately brings into opposition the subjective stance of the artist, as described by Nicolas Bourriaud (1998) in *Relational Aesthetics*, with the objective view of the scientist, which I have also engaged with in this research. He talks as if one sees the world only from one's own perspective, using the information collected from one's own sensory apparatus; eyes, ears, the touching hand and so on, emphasising the importance of using empathy. He uses very simple, straight-forward words to describe the value of information from the senses when approaching the other and stresses its subjective nature (Bourriaud, 1998, p 41).

Bourriaud assumes art to be a form of living, rather than a way of thinking; able to express

ambivalent and subtle concepts without the barrier of boundaries. He claims that modernity is like life imitating art, rather than art imitating life. His take on subjectivity is that there should be a continuous enriching relationship between the self and the world. Bourriaud says:

A definition that ideally applies to the practices of contemporary artists: by creating and staging devices of existence including working methods and ways of being, instead of concrete objects which hitherto bounded the realm of art, they use time as a material. The form holds sway over the thing, and movements over categories. The production of gestures wins out over the production of material things. (Bourriaud, 1998, p 103)

Bourriaud's curation of the Tate Triennial '*Altermodern*' was reviewed by Matt Collings (2009) in *Modern Painters*. Collings claimed that the theme was open-mindedness and being 'available to the present' and accessible to 'all subjects' [and that Bourriaud's curation, works] '...sincerely within patterns and structures that are often rather empty.' (Collings, 2009, p 18). Bourriaud's glib categorisation of strands of thought does not engage easily with practice in the community which is often messy, because of its complexity.

Grant Kester, Professor of Art History, in the Department of Visual Art at the University of San Diego in California, wrote an important text *Conversation Pieces: Community and Communication in Modern Art* (2004) that takes a dialogue, rather than text-based, approach to making art. In *Autonomy, Agonism, and Activist Art* (2007) he discusses his ideas further with Mick Wilson. Kester claims that there is a new genre of engaged practice, which he calls dialogic, rather than relational.

He pays tribute to Bourriaud for bringing many of the arguments together. His differences with Bourriaud arise from Kester's interest in practice that has a long and deep engagement with the community in which the collaboration occurs. The artist works from within rather than remaining at an 'ironic distance' from his or her collaborators. Kester states explicitly that he tries to avoid naive or complicit practice, which is how this genre of work and the relational work of Bourriaud, that tends to be more gallery based, is critiqued by art historians such as Claire Bishop. His attention is driven by community involvement. Kester

thinks the group of artists he writes about offer a valuable critique on situations which include practices with shared authorship, cross-disciplinary working, and transcultural approaches. They remain concerned with aesthetics. Critics such as Claire Bishop believe that Jeremy Deller's *Battle of Orgreave* (2001), a re-enactment of one of the 'battles' between miners and police during the 1984 UK miners' strike, offers both an aesthetic critique and a social comment on the real life situation. There is critical agreement that this spectacle of local ex-miners and ex-police, mingled with members of battle re-enactment societies from all over Britain was both socially engaged and aesthetically focused. Bishop claims in *The Social Turn* that:

Rather than positioning themselves within an activist lineage, in which art is marshalled directly to social change, these artists have a closer relationship to avant-garde theatre, performance or experimental architecture. The success of their work is not dependent upon authorial suppression, but upon the careful deployment of collaboration to produce a multilayered event that resonates across many registers. As such, they think the aesthetic and political together, rather than subordinating both within the exemplary ethical gesture. (Bishop, 2007, p 250)

What is interesting about this response is the insistence on the aesthetic experience, coming as it does from a collection of articles *Rediscovering aesthetics: transdisciplinary voices from art history, philosophy, and art practice*, where the editors Halsall, Jansen and O'Connor (2009) say that aesthetics cannot just be limited to a disinterested way of looking, using abstraction, but must also take account of historical and political sensitivities, in order to allow the full potential of aesthetics to be expressed.

Kester considers that he is moving on from Bourriaud's object-based language to an event or process-based language. He describes this practice as agonistic where the *agon* denotes a contest or its prize. This contrasts with Robert Marshall who, in the Bleakley and Marshall (2009) article on empathy and Homer, uses the less conflict-based word 'play', in preference to *agon* with its traditional masculine-heroic overtones. Thus Kester and Marshall are each dealing, in their own ways and territories, with not only the *thumos* or spiritedness, but also with the agonistic quality, of the active move towards more

collaborative practice, whether based in art or surgery.

Bourriaud's artists are immaculately choreographed and organised in advance, whereas with Kester there are workshops, often relying on craft traditions, using the creative labour of his artists' collaborators. He is interested in the ethical relationship between artist and collaborator, the interstices between ethics, aesthetics and tactics. He insists that there is permeability between art and other methods of symbol production.

In *Participation*, Claire Bishop talks about three types of links between 1960s' collaborations and contemporary practice. Her first is activation, the creation of an active subject, someone empowered by physical or symbolic participation. 'An aesthetic of participation therefore derives legitimacy from a (desired) causal relationship between the experience of the work of art and an individual/collective agency' (Bishop, 2006, p 12). Her second link is authorship; shared authorship may increase risk and unpredictability, which Bishop refers to as an aesthetic benefit of this strategy. Her final link is community, where she locates the collective elaboration of meaning, restoring the social bond, which functions within what Bourriaud (1998) referred to as social forms. Bishop also talks about '...artistic practices since the 1960s appropriate social forms as a way to bring art closer to everyday life: intangible experiences such as dancing samba as demonstrated by Helio Oiticica' (Bishop, 2007, p 10).

The use of participation and collaboration enhances the political power of the work and deepens the involvement of the community, creating a sub-culture that is open-ended; both part of the discussion and also tangential to it. It can be safe yet challenging.

Object making and use: objects from the social context that are no longer doing work

The value of objects in the context of art practice is examined. I question the different ways that objects are used in practice. Bishop (2012) builds on Foster's descriptions of the social artist but challenges his apparent assumption that it is the objects produced in relation to human culture that are important. For example, Jeff Koons work, *New Shelton Wet/Dry Double Decker* (1981), a Plexiglas cabinet containing two vacuum cleaners, which Foster

(1996) describes in his chapter on *The Art of Cynical Reason*, may be a cultural artefact, but not in the social context that she thinks is most compelling. Instead Bishop suggests that it is the process, with or without the production of objects, that is paramount. This is relevant to healthcare, which is built around the quality of the processes providing the care, as well as the quality of the objects involved, such as new hip joints or incubators.

Object making and use: objects from the social context that are doing work

In Milan Knížák's *A Demonstration for All the Senses* (1964) or *A Walk Around Nový Svět*, as it was also called, participants were given an object to carry for the duration of the Prague walk, and were led past various activities, including a man lying on the ground playing double bass, a man sitting eating at a table and another man glazing a window and then breaking it. After the event, which was the active part of the participation, Knížák asked people to go home and consider the intervening time as a second type of participation. The 'enforced action' and 'spontaneous reaction' were two types of participation performed by two types of participant, active and passive, and he felt that both should be encouraged. His participants became 'unwitting artistic accomplices' (Bishop, 2012).

Knížák moved on to develop lists of bossy recommendations which Bishop (2012) describes as life-affirming. Although some of them might have been, such as the recommendation 'Live!', others were not, such as, 'Commit suicide!', or 'Drink 2 quarts of rum a day for 7 days' followed by 'Drink nothing for 3 days'. Fortunately, when he visited the USA, his events were notable for their quietness. In *Lying-Down Ceremony*, New Jersey (1967-8) where participants were invited to lie down blindfold, or *Difficult Ceremony* (1966-9) in New York, where a group of people was invited to spend 24 hours together without eating, drinking, talking, getting high or communicating in any other way, before separating in silence 24 hours later. In *Difficult Ceremony* the situation was complicated by the fact that the participants had to manage without the objects of comfort (food, drink and drugs, which are indirectly referred to by the words eating, drinking and getting high). Participants lay down and were blind-folded or asked to do uncomfortable things, such as spending long

periods together without the usual social comforts. There are parallels between these situations and the ones that patients, and to a certain extent staff, experience in hospitals. I was attracted by the idea of manipulating scenarios within hospitals so that they became art events that offered staff some discomforts, but also had an amusing turn. Knížák's work has an irony that is compelling and his list of activities is sufficiently reminiscent of the discomfort of hospital that he is of relevance to my work.

Objects do work by interacting with people in performances. They can be used directly or indirectly, to generate meaning and connection with social times and places. This is very different from objects which are displayed in museum spaces, divorced from their context, and so may appear to be more distant from society. As medical care and hospital environments involve the use of so many objects, from bags of blood to whole body magnetic resonance imaging (MRI) scanners, I was interested in artists who used objects in performances.

How artists organise people in time and space:

Objects used in staged activities, performed in particular spaces at defined times

Knížák used items in carefully staged activities. In these events, art and life were often treated as one unit; for example, someone sweeping the stairs might, to Knížák's apparent surprise, be considered an artist. In Prague, while the Soviet occupation persisted, he organised seven concerts that were banned. Having been closely associated with *Fluxus* and following conversations with Alan Kaprow about Happenings in New York, he returned to outdoor ritualistic events and developed the *Stone Ceremony* (1971). Participants stood silently in the stone circles they placed around themselves, isolated in a bare landscape. These ceremonies changed from being disruptive, to becoming quieter and more ritualistic, emphasising the importance of working in a group. Knížák's work also suggests that the act of spectatorship was important when political points were being made in his brief activist events of the early 1960s. Claire Bishop (2012, p38) talks about the art object as not only aesthetic, but also an intermediary, a 'third term' to which both artist and viewer can relate.

Artists moving out into cultural and industrial spaces

Artists have used innovative ways to participate and engage others in social actions for many years. John Latham, of the Artist Placement Group, claimed that 'context is half the work', an idea which chimes with much work beyond the studio space.

Claire Bishop (2012, p166) notes John Cage's *4' 33"* (1952), 'a 'silent' performance in which peripheral sound becomes the composition's content'. Frances Marie Uitti, a radical cellist read Cage's *Lecture on Nothing* (1991). She convinced me of the power of his work and the potential for this instrument, as punctuation. Uitti, whose father was an engineer, plays with a double bow, one above the strings and the other acting as a shadow, below (Watson, 1995).

Involving the spectator in acts of participation in social and gallery spaces

Bishop (2012) claims that there is not a sharp division between the active forms of political collaborations and the more passive spaces of the gallery. She agrees with Jacques Rancière who points out that even if the performer does not know what he wants the spectator to do, he knows at least that the spectator has to do something. Switching from passivity into activity is important. The social rituals of a group may be vital as a way of passing work out under the radar. Bishop uses Rancière's ideas to explore other situations where she believes that a binary (as in active or passive) is not applicable. Work in a hospital tends to involve a continuous switching back and forth, between passive and active, as ideas are formulated around investigation and treatment, the patient bringing their own particular 'take' on an agreed course of action. In a simple and similar way, I expected staff participants to do something with me.

Why artists engage with society: exchange of services for social transformation

Bishop (2012) speaks of Delegated Performance, the name she gives to work when the artist actively engages others in society to perform the work, rather than performing it

themselves. Jeremy Deller's *Acid Brass* (1997) is a good example. He worked with amateur musicians from workers' brass bands in the north of England, whom he invited to perform contemporary pop rather than their traditional music. Two things are striking. Firstly, the success of the project, as the musicians made CDs and gave repeated performances and Deller's interpretation was represented as a complex diagram, connecting the two working practices. The piece seemed to take on a life of its own. Secondly, it is important that this was a real band, with a genuine connection to historical working class life. Bishop describes the practice as having a cool irony. However, for Deller and his band of musicians to have set up an exchange that has its own rhythm seems an authentic gift, even if ironic. The musicians in the band work together as a team, much like the staff of a hospital work together so that the patient can leave their care and goes out into society.

Over ten years later the band are still winning international competitions and playing Acid House music. Deller brought the two idioms together as he considered them both to be expressions of folk art. It seems as if this innovative band used the socially engaged practice of the art world just as powerfully as Deller used their knowledge of music and enterprise. Hal Foster (1996) addressed the place of art and theory, commenting that anthropology practices the science of alterity, takes culture as its object, remains contextual, addresses both the social and material culture, whilst remaining interdisciplinary. From an anthropological point of view these objects (the CDs) and the services (the concerts) are transferred between members of a local culture and as such represent gifts as well as art objects, moving within and between generations, so that the artwork is part of society, beyond the gallery.

The ethics of engagement: using the human body (one's own versus the bodies of others)

Santiago Sierra's work made in Havana was, for me, the most uncomfortable piece discussed by Bishop in *Artificial Hells* (2012). *A 250cm line tattooed on 6 paid people* (1999) shows a line, stretching 250 cm across a line of six men, drawn by injection of black

pigment into the skin, along their backs at the level of the shoulder blades. The men were employed to display the line by standing side by side. The work made a pointed demonstration of the fact that you can pay people to do almost anything, no matter how humiliating. The artist paid men to be his canvas or paper, for that is where lines are usually drawn in art. This approach contrasted with artists of the 1960s and 70s such as Marina Abramovic and Lygia Clark, who used their own bodies and participated within the activities they set up. The collaborative piece *512 Hours* (Abramovic, 2014) at the Serpentine Gallery in London was a good example. She remained in the presence of a total of over 100,000 visitors and participants, eight hours a day, six days a week over the summer. Bishop suggests that the stamina required in such durational work was replaced, in art such as Sierra's, by an economic arrangement with another subject and it is in this respect that the work becomes transgressive.

The ethics of it are questionable. Bishop (2012, p223) describes her phenomenological encounter with the piece, which she found 'disturbingly cold and alienated', a feeling which was enhanced by the fact that the documentation of the financial transaction, via an employment agency, was also displayed as part of the work. Sierra's motives were not transparent. The documentation from the employment agency made it explicit that he had no direct relationship with these men. It is unclear what he felt about their fate after taking part in the exhibition.

What is striking about Sierra's work is that there is something cruel about it; an empathy misplaced and abused. Sierra notes that people need work; he provides it. Bishop suggests that she finds the work distasteful. In Sierra's practice social well-being is not enhanced by participation in his work. He draws attention to the poor way some companies treat their common labour force, which is in contrast to the commitment to good practice which is generally found in the NHS.

Financial relationships rather than ethnographic ties between participants and artworks

As the men are permanently marked by this tattoo, this has an implication for them as social beings. Although one's initial response may be suspicion, these minimal marks commissioned by a famous artist, were taken up readily by the paid participants. The men suffered no serious harm, have a souvenir of an event where they were briefly famous and Sierra managed to make an important point about rich entrepreneurs having the ability to humiliate their workers.

I examined works shown at Tate Modern (Sierra, 2008) and the Lisson Gallery (Sierra, 2002b) over the last fifteen years: tattooing a line on the backs of prostitutes; spraying solidifying foam over a line of Iraqi refugees, covered in protective clothing, such that the foam and plastic coats remain as a sculptural form when the Iraqis walk away; or persuading an Irish street vagrant to live behind a brick wall for fifteen days in the IKON gallery in Birmingham (Sierra, 2002a). In the last piece, the man said 'No one has ever paid me so much attention'. The arrogant approach of this practice, rationalised as activities occurring within culture, contrasts it with the pragmatic but caring approach in the health service.

Bishop (2012, p39) repeatedly returns to the question of ethics in art and draws a distinction between art that reflects on life and art that reflects upon art. She acknowledges that Sierra, by using people as his medium, addresses some real world behavioural and political power relationships, such as inequality and class. However, she clearly feels that it is important to address the paradoxical aesthetic and ethical questions which his works prompt. I critique Sierra's work in Chapter Six, in relation to my own collaborative practice.

Objects from the social context that are doing therapeutic work

I first became familiar with the work of Lygia Clark and Helio Oiticica at Tate Modern's *Open Systems: Rethinking Art c. 1970*, in 2005. I have vague memories of moving through Oiticica's multisensory labyrinth of exotic colours, textures and recorded poems (made for New York in 1972) and observing others donning Clark's *Sensory Objects* (1966) and

Dialogue Goggles (1968); but what I clearly remember is receiving a drink of orange juice before I left the room in which the work was displayed. At the time I did not dwell long on the work but kept the mini-catalogue in my studio as a drinks mat, not consciously aware of the significance of my gesture.



Figure 8. *Dialogue Goggles*, Lygia Clark (1968), shown in *Open Systems* (2005), Tate Modern

Clark developed inter-subjective events to explore the potential of working in a group, with strings and thread, soft fabric and clothing that covered the head and eyes. Despite having no formal training in psychoanalysis, she was interested in the therapeutic potential of her work with participants who had psychological problems, varying from neuroses to psychotic crises. She kept detailed records of her experiments (1976-82), noting that the participants improved with her interventions, particularly the most disturbed ones. (Brett, 1998)

A relationship to Primitivism: Lygia Clark

According to Guy Brett *Unofficial Versions*, in Susan Hiller's *The Myth of Primitivism*, Lygia Clark and Helio Oiticica:

... went back to 'primitive' materials, to the body, to 'primordial' sensations, relationships. In fact, its radicalism was of another kind. An acute sensitivity to traditions and tensions in their own environment is combined with a searching questioning of the artist's production in a corporate, consumer society. (Brett, 1991, p 132)

A similar tension, between a disrupted and disrupting hospital environment, used as a

territory in which to work as an artist and doctor, encouraged me to introduce some of the experimental practices I had researched, for the benefit of staff.

Brett records one particular work of Clark's: *Cannibalism* (1973). In this event participants, who were blindfolded, suggested by touch, that they were eating from the stomach of another participant. It was described by Lygia Clark:

This goes beyond a purely muscular or motor linking between body and body. It is something more interior like entering each others' bodies. There is no spectator here. It is a monstrous idea turned into intimate joy (Brett, 1991, p 132).

Further use of empathy as a 'projection into' or 'resonance with' phenomenon is evident in Guy Brett's writing on Lygia Clark in *Out of Actions: between performance and the object 1949-1979* (Brett 1998), where he feels that in the 60s and 70s this expanded field of performance was not fully understood.

It will not be until the two subjects of art and medicine have changed that the full implications of her work will be understood. Clark entered an area between art and medicine, so that her discoveries cannot be understood in one field only. (Brett, 1998 p 206).

Her simple and economical gestures and objects can be understood as if they are the body breathing. The way Guy Brett describes *Air and Stone* (1966) encapsulates this sensation:

It is not an art object but a proposal: simply inflate a plastic bag, seal it, place a stone in one corner and squeeze the bag between your hands... The interplay of solid mass and empty space, of weight and lightness, sums up the whole of sculptural history, yet the object is analogous to a body, breathing between our hands and sustained by our gestures (Brett, 1998 p 204).



Figure 9. Lygia Clark with *Air and Stone* (1996)

Lygia Clark said, 'We are the mould: the breath inside the mould is yours: the meaning of our existence.' (Brett, 1998, p 204). In one of my final events for this research (described in Chapter Six) I found myself experimenting with Clark's ideas in the *Elixir* gallery. I left a red alabaster egg, that I had bought as a child, on an inflated plastic bag on the windowsill of the gallery while I worked, cutting Mobius strips. There was something calm and elemental about stone and breath that joined me into what felt like a loop of life, as colleagues came and then disappeared to continue with their healthcare work.

Clark was not working in the body art field but in a space where there was an expanded and multiple sense of self, where the distance between subject and object, artist and spectator, spectator and participant was negligible. Guy Brett says:

The implications of her innovations in the sixties and seventies context of 'live art' is the transformation of the artist/spectator relationship. No longer 'Me the artist. YOU the spectator', in Ricardo Bausbaum's words, but 'YOUwillbecoME'. (Brett, 1998, p 206)

For this reason, Clark distinguished her work from many forms of body art and performance, taking the radical view that these forms perpetuated the myth of the artist 'to the extent which the myth becomes the object of the spectacle.' (Brett, 1998, p 216). She was against the fetishisation of the artist in society and was much more interested in the value of art as a

form of dialogue. Brett reconsiders the relationship between performance and the object, citing it as both complex and paradoxical.

My aim, with the drawing investigations, was to give participants the opportunity to escape their localised worlds for a few minutes. When they came together in groups, they made objects with their colleagues as spectators, sitting or standing next to them, so that the work existed within complex relationships. Brazilian writer and psychologist Lula Wanderley, who worked with Clark and some of her Relational Objects, described them as:

...not on a sensorial outlining of shape nor some quality of surface but [on] something that dilutes the notion of surface and makes the object to be lived in an 'imaginary inwardness of the body' where it finds signification. This is where the frontier is broken between body and object (Wanderley, 1993, cited in Brett, 1994, p 58).

Remarking on the social space of art production, Lygia Clark said:

We arrived at what I call a 'collective body' an exchange between people of their intimate psychology. The exchange is not a pleasant thing...and the word communication is too weak to express what happened in the group. (Brett, 1987, p 204).

This sort of reaction was apparent with the people I worked with, who either came together or formed groups with me, especially during the early *Big Draw* events. Lygia Clark's Relational Object experiments demonstrated that interactive practice was possible. Experience was 'locked in the body's memory at a non-verbal or pre-verbal level' (Brett, 1998, p 206).



Figure 10. Lygia Clark's experiments with groups of participants in *Elastic Net* (1973)

In Clark's experiments with groups of participants in *Elastic Net* (1973), she thought that it was important for her participants to use thought as if it were food and to allow their gestures to express meaning. The response of my participants was consistent with a rediscovery of the sensual and instinctive sides of life. Lygia Clark was useful as she valued the development of a systematic art which included a therapeutic 'appointment': a structured approach with the aim of improving the sense of well-being of a participant or patient. She developed the concept of a collective body, as we do in the hospital. It is not always a comfortable experience: staff, under strain for one reason or another, sometimes exhibit a physical and mental anxiety that they share with others. I considered her pieces *Elastic Net* (1973) and *The House is the Body: penetration, ovulation, germination, expulsion* (1968a), which were displayed at the Hayward Gallery (2010-11). Clark's four levels, occurring simultaneously as a way of *Structuring the Self*, a psychophysical therapy, talk about liberation of the viewer to participate in the work:

...through a progressive destabilisation of the art object; through a systematic transformation of the spectator into creator; through the dissipation of the traditional notion of authorship; and through the gradual abandonment of the artistic milieu together with its modes of production and consumption. (Fabião, 2010, p 61)

Claire Bishop (2006), in her book *Participation* emphasises the social nature of working in this way, noting that the projects she describes differ from performance art as they strive to:

...collapse the distinction between performer and audience, professional and amateur, production and reception. Their emphasis is on collaboration and the collective dimension of social experience. (Bishop, 2006, p 10)

Bishop includes letters between Lygia Clark and fellow Brazilian artist Helio Oiticica (1968-9), with whom Clark had an intense dialogue, sustained throughout their careers. Clark's philosophy, noted in a letter to Helio Oiticica, on 26th October 1968, was to 'eat a new 'pear' every day to see if it's good or not' (Clark, 1968b, p 110). The flavour of the pear and the sensuality of the act of eating were an example of 'living in the moment'. Diversity of positions and the 'poetic lived experience' (*vivencia poéticas*) were important in the confirmation of reality (Clark, 1968b, p 110).

Clark gives the object an important context:

'Since *Caminhando* (Walking, 1963), the object for me has lost its significance, and if I still use it, it is so that it becomes a mediator for participation'. (Clark, 1968b, p 110).



Figure 11. *Caminhando* (Walking), Lygia Clark (1963)

Guy Brett puts this idea into context in *The Proposal of Lygia Clark* when he says:

In chronological terms her work began in the sphere of art and ended in a practice that she termed 'therapeutic': a form of experimental freedom, reparation, or 'healing.' This came about through a temporal evolution of her

compelling audacity and logic, but in another sense it was not a move from one sphere into another. Both remained simultaneously present, and both are changed. Just as it is valid to trace the evolution of Clark's work forward from her early geometric-concrete abstract art to her eventual therapeutic practice, it is equally valid to trace her work backward from the eventual therapy to a beginning in the aesthetic consideration of space and time. (Brett, 1996, p 419)

Clark's proposal is open and important, as it allows the object to take on multiple meanings.

Lula Wanderley says:

Instead of an object in which her own expressivity was encoded, she proposed one that has no identity of its own. This object only took on meaning in relation to the participant's fantasy, and 'only in the act of a relation established with the body. (Wanderley cited in Brett, 1996, p 419)

Clark's methods are still practised in Rio de Janeiro, as noted by Connie Butler, who co-curated the exhibition *Lygia Clark: The Abandonment of Art, 1948–1988* at MoMA (2014), in an interview with Julia McCormack. They discuss the importance of the continuing work of psychologist Lula Wanderley, in Rio, using the relational objects proposed by Lygia Clark. Butler felt that Wanderley's work, and that of his wife, were part of the therapeutic alliance forged by Lygia Clark in her pioneering work (McCormack, 2014).

In 1969 Helio Oiticica wrote:

...the most recent experiences of Lygia Clark have led her to fascinating proposals as she discovered that certainly her communication will have to be more of an introduction to a practice that she calls cellular: From person to person, this is an improvised corporeal dialogue, that can expand into a total chain creating something of an all encompassing biological entity.... The idea of creating such relations goes far beyond that of a facile participation, such as in the manipulation of objects: there is the search for what could be described as a biological ritual, where interpersonal relations are enriched and establish a communication of growth at an open level (Oiticica, 2006, p 115).

The actions in Big Draw events related to the cultural activity of art-making and occurred in a space that was set aside for the 'delivery of a service'. They challenged the notion of what was going on in that space. Oiticica emphasises the open level of communication:

...because it does not relate to an object-based communication of subject-object, but to an interpersonal practice that leads towards a truly open communication: a me-you relation, rapid, brief as the actual act; no corrupted benefit, of interest, should be expected – observations such as ‘this is nothing’ or ‘what is it about’, etc., should be expected; an introduction as initiation is necessary. The elements that are used in all of these process-based experiences, a vital process, are those that are part of it instead of being isolated objects: they are orders in a totality...’ (Oiticica, 2006 p 115)

Knowledge of Clark’s practice gave me the opportunity to build on the concept of drawing the body, lying on paper or a mat on the hospital corridor floor, both as a sensual experience, when one is drawn around, and as a disconcerting experience. From my own pilot experience of lying, eyes closed, in the corridor before *Big Draw I* (Chapter Four) I heard the sounds of the hospital but felt slightly separate from it, in a way that was quite therapeutic. I identified with the patient, who has to lie down to be examined, and yet I was lying down to relax and draw.

Origins of my collaborative research arena

Possibilities seemed to open up when artist Christine Borland (1997), picked for the all women short list for the Turner Prize, exhibited her leather, obstetric birthing doll. The short list also included Cornelia Parker, who taught me at Goldsmiths College. Parker encouraged me in the production of an installation of yellow bin bags of material, the colour of hospital clinical waste.

That year, Cornelia Parker exhibited a garment, a black coat-suit hanging on a wooden coat hanger and bits of a shed blown into tiny fragments by the British Army. My interest in collaboration, socially engaged practice and the object had begun, given confidence by the explosive art of Parker, and Borland’s engagement with birth and the medical profession.



Figure 12. *Phantom Twins (Birthing Dolls)*, Christine Borland (1997), Tate Britain

Tilda Swinton and Cornelia Parker (1995) collaborated on a performance titled *The Maybe* at the Serpentine Gallery in London. Swinton lay, apparently asleep, in a glass case for eight hours a day, the centrepiece of an exhibition that featured the possessions (and one brain) of famous dead people. In contrast, in my performances I was free in the gallery, not encased in glass. I moved almost imperceptibly, drawing by slithering along the floor of the gallery, referencing worms, snakes and snails; leaving my little trail of pencil markings behind me.

Later, I extended the offer of a participatory relationship in art practice to hospital colleagues who would not consider themselves to be artists. I used a drawing tool (a bottle containing alcohol hand gel) at an emergency medical staff committee meeting, convened to discuss the plight of the poorly managed, bankrupt hospital. The consultant body called the management to account and asked to be told what was going wrong and what would be done to solve the problem. I squirted their hands, both consultants and managers, in a performance I called *Cleanse*, which I describe in more detail in Chapter Four.

My relational and dialogic practice was developing in the hospital where I was working; intervening, inviting participation and social relations, coinciding with a time of crisis. The staff enjoyed its subversive nature whilst accepting the practical message about hand-washing. This event was described by Rosie Millard as being ‘...all about evoking memories’ in her book *Tastemakers: UK Artists Now* (Millard, 2001, p 177).

In the words of Nicolas Bourriaud in *Relational Aesthetics*:

One of the virtual properties of the image is its power of linkage.... flags, logos, icons, signs all produce empathy and sharing, and all generate bond. Art (practices stemming from painting and sculpture which come across in the form of an exhibition) turns out to be particularly suitable when it comes to expressing this hands-on civilisation, because it tightens the space of relations....' (Bourriaud, 1998, p 15)

Maintaining strong relationships in the practice space for art, medicine and health was important during the anticipated period of change. My aim was to use drawing to explore the practice of empathy within this time and space.

Reflections on Socially Engaged Practice

Chapter Three has reviewed the socially engaged context within which the research took place. It began with scrutiny of the gift economy, a setting in which goods and services are passed between individuals in a cycle of exchange that forms an important part of society.

The texts by Bishop (2012) and Foster (1996) on 'artificial hells' and 'the real' provided an analysis of art's avant-garde developments, beginning at the first world war, then 1950s and 60s (neo-avant garde), late 60s, postmodernism, the artistic crisis around the fall of the Berlin wall in Europe in 1989 (and similar related events in other places at other times that reflected their own political crises). Bishop's text followed up events in the 21st century.

Bishop and Foster addressed the question of what was important about flashpoints. They articulated the artistic response to over controlling regimes, whether from the left or right. Both made it clear that artwork of a socially engaged nature emerged during upheavals in society. And both highlighted how artists respond both positively and negatively to this; sometimes with intelligence and sensitivity and at other times with a crassness or overindulgence. The way that the ground was laid for these changes, the ethnographic focus on exchange and the circulation of the gift within society, the notion of difference or science of alterity, and how that influenced the flow of ideas and the practices of groups within society were discussed.

Claire Bishop (2012) emphasised the importance of the actions of artists who use delegation, such as Knížák, in the 1960s, who initiated simple activities which were taken to extremes. In this context I have referred to Jeremy Deller's work on *Acid Brass* (1997), a collaboration with a works' brass band that produced a lasting effect in the local organisation, fusing two genres of music to produce a new form, another identity and a lasting legacy.

My interest in socially engaged practice focused on objects and how they were used to create meaning, by considering the making processes, the form and the work done by the objects. Entering a social space beyond the studio opened up opportunities in relation to durational work and raised questions about the rationale and ethics of engagement, especially in relationship to large organisations, such as the NHS.

Both Bishop and Foster highlighted the importance of an uncomfortable but essential tension between critique and practice, which sometimes pull in opposite directions. Bishop's elaboration of the concept of participation demonstrated the importance of social practice as a cultural entity. Theoretical discussions between critics Bourriaud, Bishop, Foster, Kester and Brett, highlighted the struggle to understand work in a social context outside the gallery, from the large scale collaborative works of Jeremy Deller to the therapeutic arts practice of Lygia Clark. Assessing the value of this type of work remains difficult but galleries and museums increasingly use educational practices, whether time-based and performative or involving the generation of a lecture or publication.

As my research took place in a situation where the gallery was a corridor or a meetings room, embedded in a social context, these debates and practices were important influences in my collaborative research arena. The attitudes of artists towards their workers varied from paid subordinates or executors to active participants and collaborators, who might benefit from the collaboration and learn from the experience. I located myself in a contextual field with artists and critics whose work was concerned with empathy, in collaboration with

others, rather than artists who use paid participants to create a sense of alienation. In Chapter Six, to make this distinction clear, I contrast one of my hand cleansing encounters involving a group of healthcare workers, with the tattooing performance organised by Santiago Sierra, who employed a group of sex workers, paid with drugs.

This is an appropriate point to move on to Chapter Four, where the methodology and ethical code for the research was elaborated and the pilot events introduced. The combination of the multi-layered nature of the study, beginning with drawing or the making of *bocca*, and the organisation beyond the studio, in which the research took place, meant that as time progressed and complexity increased there was a natural shift towards paradoxical socially engaged practice.

PART B: THE PRACTICES OF DRAWING AND EMPATHY IN THE HOSPITAL ENVIRONMENT

Chapter Four. Methodology: The Practice of Empathy

‘I consider laughter preferable to tears.’

(John Cage, *Water Walk* comment on TV game show *I've Got A Secret*, 1960)

Summary of Chapter Four

This chapter introduces the methods of action research that were used to explore the empathic interactions between staff of the Queen Elizabeth Hospital Woolwich and other hospitals during the mergers, through a series of drawing events. The annual cycle of activities usually began in October. The action research approach, used throughout, is described. It was informed by the structured drawing experiences developed in the years prior to the first merger in April 2009. Centrally, I used novel tools, such as the presence of cello sounds within *Big Draw* events, alongside traditional drawing skills, to explore familiar activities, such as the act of lying down. I found that asking staff to make *bocca* (small sketches) of animals, drawing with both hands at the same time, eyes closed, or lying on the floor to draw or be drawn, was an interesting way of approaching the complex practice of empathy. These approaches arose from participatory experiments with staff.

In this Chapter my practice addressed the research question of whether drawing could be used as a way of working out how to sustain and augment the craft skills of medicine and to explore emotions and thoughts, in empathic therapeutic interventions, during the pilot studies.

The issues under question were approached in two main drawing events. The first one was in October 2007, involved the making of small ceramic *bocca* (sketches) and then attaching them to fishing net, which was used both to display the work and to act as a safety net¹. Then in October 2008 the second pilot exploration trialed the practice of

¹ The hospital services were to be reconfigured, according to a plan called A Picture of Health. Work on this plan started in 2005 and was ratified in 2008; changes began in 2009. Evaluation by the King's Fund was published in 2011 (Palmer, 2011)

double-blind drawing. By the end of the second year there was an established methodology of action research, which was practice led, based upon the combined approaches of drawing, socially engaged art and medical practice. The work was analysed and evaluated in the context of medical humanities, collaboration and the psychoanalytic theory and practice of empathy.

The context of the project

In my research, the practice of drawing is posited as methodologically useful in an analysis of what might be 'dangerous' about the practice of empathy, as explored by Jane Macnaughton (2009) in a medical context. The problem-based approach of action research, first defined by Kurt Lewin (1946), has been used in medical contexts since 1993. It has the advantage of being useful when pulling together many different elements. Action research, in the context of my research project, consists of a practice in which one repeatedly goes back to the work, scene, drama or situation, until one finds the problem or missing link. The action consists of intervening in the problem area with an action that may make links in the minds of the staff. The act of returning to the action repeatedly may strengthen those links if they work and the benefit of action research is that it can take into account a system that is not closed to external influences and so can address evolving situations. In Chapter Six, by the end of the experimental phase, the interventions were smaller, subtler in some ways but more extreme in others, befitting the fact that by then the Trust had gone through three hospital mergers and a disaggregation.

This methodology has feedback programmed into it, enabling the researcher to take the difficult issues raised by the research and reincorporate them into the study, allowing the research to be re-examined.

The cycles were enriched year on year, allowing the organisation (the hospitals of the Trust) to benefit and incorporate the learning into their change management. If staff became aware of alternative ways of managing a situation, they might empathise better with the individuals they encountered. They could explore different ways of working. My research activities encouraged staff to choose an arts or humanities based approach when addressing the issues brought up in the throes of change. This possibly improved their capacity to 'switch practices' during patient care or to think from a different

perspective. Medical management of the physical body and empathy with the individual required subtle and powerful approaches. An arts led practice, used at critically important moments when standard practices were not working, was investigated.

Action research presupposed active participation and by its nature was democratic, so that the research had a broad-based ownership and authorship. In my PhD, the ideas about empathy and visual language came from research about other practitioners in my arena and from the experiences of colleagues. These were concentrated in the annual drawing events using the action research approach. The cycles of research were fed by the actions shown in the diagram below. The basic cycle is described here, followed by the annual cycles undertaken in the early pilot phase, the middle 'problematic' merger phase of the research and the late critical phase, which included the Trust's disaggregation.

My investigation into drawing and empathy began in October 2007 when the first experimental event of the PhD took place. I was interested in the idea of taking a broad approach to empathy, imagining not only being in the other person's shoes but also exploring the other side of oneself.

My literature survey and contextual review form the first three chapters: medical humanities, psychoanalytic approaches to empathy and collaborative practice. I needed a methodology that allowed me to address different aspects of the practice of empathy within a complex arena. Action research enabled me to address the procedural aspects of empathy, particularly mirroring, feeling (attunement) and thinking (cognition), and then to build them into a methodology over a seven-year period, as evidence was gained from repeated cycles of professional practice, critical reflection and adjustment.

Before discussing details of methodology, it is necessary to explore the nature of the events I created during the first three *Big Draw* years. I remained convinced that a commitment to empathy in both art and medicine was paramount. I considered the anxieties of Dr Jane Macnaughton (2009), Professor of Medical Humanities at Durham University, who said:

We have a momentary mirroring of that patient's feeling within us, but what we maintain is sympathy (feeling for but not with the patient) and the need to

respond. It is potentially dangerous and certainly unrealistic to suggest that we can really feel what someone else is feeling. (Macnaughton, 2009, p 1941)

My thoughts, intuitions and experiences in the first event *Catching Empathy* (2007), echoed Macnaughton's, so I proceeded carefully, taking risks only when I became confident of the situation.

I set up environments that resonated with aspects of my participants' lives: their work-setting, a domestic space and a holiday feeling. I did this by developing events that created a time and a place where there might be an exchange between two types of the 'familiar', one work-based and one from outside the hospital. My hope was that participants would feel comfortable within this space, so that tacit knowledge from one arena would pass to the other, without conscious effort on their part, and give valuable insight into the way that empathy was practised within this community.

Between October 2007 and November 2008 I conducted several practice led events to work out which materials and methods engaged my participants. The work began with a corridor drawing event, open to all staff of the hospital (and patients and relatives if they wished to join in). I modified my workshop style as I went along, using an action research approach. I started with simple gesture-based drawing activities, which potentially reflected on a medical context, for several reasons: firstly, empathy may be expressed in gesture as a form of embodied action simulation and this behaviour may be read without recourse to conscious thought; secondly, discussion of the activity promoted reflection, allowing me to consider scenarios relevant to medicine.

Over the seven-year period I used a mode of action research advocated by Somekh (1995) and an educational research model recommended by the London Postgraduate Medical and Dental Education (LPMDE, 2014b). This organisation championed excellence in medical education and developed a well-trained and motivated faculty of clinical teachers. It took the Somekh approach as it was similar to the pattern of medical audit. The problems considered were practical in nature and there was an important cycle of investigation, returning to the issue, feeding changes into the loop and then monitoring what happened as a result of the intervention. There was a clear incentive to change, as the details of practice were revealed.

...practical problems are considered and...the feedback, changes and subsequent evaluation of change are all part of the research – rather like audit in its cyclical design. Action research is a common mode of educational research. It appeals to those who like the idea of change and the feeling that the research they do actually contributes to it. It joins together both research and implementation, and is a much messier, more participative research method than most; so people who start it should not be those who demand precision or decimal points in their answers, and they should enjoy being involved with the teams and individuals who actually put the changes into practice. (London Postgraduate Medical and Dental Education, Research design and methods, 2014b, p 1)

Figure 13. The action research cycle (Denscombe, 2003)



The above cycle of action research presents the ideal closed system of professional practice. As the hospital functioned as an open system, richly connected to other communication networks, it was open to ideas from exhibitions, current political events, and from other institutions, such as art galleries and art schools. These influences became increasingly apparent as the research developed. A web of practices was woven, with interstices to high art and popular culture, in which the action research took place.

Research design

This research dealt with the real problem of maintenance and development of empathy by the staff, within a live situation: the merging, disaggregation and remerging of five different NHS hospital Trusts into two functioning groups. The final organisational structure of these two groups did not emerge until the fifth year of research. The uncertainties challenged the ways individuals interacted, often throwing them into situations where lines of command and future plans were not clear and solutions to problems were provisional. Here, empathy was both important and difficult. It was not easy to put oneself in the shoes of others, when surrounded by anxiety and uncertainty on all sides.

The first action research cycle (Early Phase) began in October 2007 in one hospital. Three hospitals merged managerially from April 2009 to form South London Healthcare Trust, including the base site, Queen Elizabeth Hospital, where the pilot study took place. During each year, a cycle of professional practice (participatory events and lectures) was followed by critical reflection and evaluation, including meetings, presentations and discussions at University of the Arts London and the Hospital's arts steering group. This cycle identified problem areas and need for change. This was followed by a time of systematic enquiry (reading, searching for references, writing and further discussion) that then led onto strategic planning for the next year's events. This practice was repeated year on year throughout the three practice led phases of the project described in Chapters Four, Five and Six, respectively.

I initiated the research during 2006/7 in the Queen Elizabeth Hospital, where I worked, in response to poor staff and patient satisfaction, which in the years prior to the mergers were in the bottom 20% nationally. I hoped that the research might address problems, propose solutions, minimise deterioration in empathy and facilitate insight.

The core practice, drawing, was embedded in a longitudinal study of drawing based events, over a period of seven years, so that a similar body of staff had the opportunity to participate in these collaborative events.

The practice of empathy: an introduction to the events

I focused on the way people collaborated with me in the production of drawings and how this might be relevant in art and clinical practices. I looked for evidence of the effects of drawing practice. Drawing was used to aid investigations, sustain the craft skills of medicine and explore emotions and thoughts, in empathic therapeutic interventions.

This was a longitudinal study, located in a hospital, rather than a set of discrete events taken from life and then displayed or performed in a gallery. A couple of months into the first phase, performances and artworks were moving back and forth between the hospital and arts institutions, such as University of the Arts London and other galleries nationally and internationally, depending on the needs of the staff and the opportunities available. As artist-practitioner, I had senior roles within the arts, clinical and educational frameworks of the hospital and within the wider educational setting of London Postgraduate Medical and Dental Education. As such I had a practice that was generally less constrained than a freelance artist-practitioner but sometimes my diverse roles brought in constraints and problems. This was counterbalanced in the final year of the research (described in the latter part of Chapter Six) when I became a volunteer rather than a paid member of staff. As such I was still able to comment more but had less access to privileged information.

Explanation of the ethical code adopted during the research.

My ethical approach echoed *Good Medical Practice: duties of a doctor* from the General Medical Council (2014). I paraphrased and reused their words in many contexts, throughout the thesis. This was summarised as follows:

Patients must be able to trust doctors with their lives. To justify that trust there must be respect for human life. Similarly, participants in arts projects have to trust the artist with their minds and bodies, during the times when the artwork is being developed.

For a doctor the care of the patient is his or her first concern. For an artist the encounters with the participant and the artwork are her or his first concern. For both professionals there is an expectation of knowledge and skill.

The safety, dignity and comfort of patients are very important to the doctor. My aim was to minimise risks in my medical practice in order to preserve safety, dignity and comfort of patients. As an artist, I sometimes wanted art practice to provoke feelings that included the uncomfortable, undignified and unsafe. These feelings happen in medicine, especially during evenings and weekends, when the risk of making an error of judgement is greatest. I realised that these feelings were, therefore, worthy of investigation. In contrast to my priorities in medicine, where I minimised them, within my art practice, I maximised these conditions, in order to provide an arena for experimentation that felt real.

How did this influence my claim to ethical practice?

I promised myself that I would treat people as individuals and respect their dignity. They had a right to confidentiality and to contribute to my research collaboratively. As artists, and I considered all my participants to be artists (Beuys, 1973), they had a right to have their work acknowledged. There was no pressure to participate.

I continued to work with colleagues in a way that best served the interests of participants and patients. I was honest, open and tried to act with integrity, even when my approach as an artist was teasing.

I did not discriminate unfairly against patients, participants or colleagues. I did not abuse patients' trust in me or participants' trust in my processes; neither did I abuse the public's trust in the professions of art or medicine.

I considered myself to be personally accountable for my professional practices and was always prepared to justify my decisions and actions.

How did I interpret the ethical code in practice?

Firstly, I ensured that I always fulfilled my medical practice hours, and gave art a similarly high profile. On two occasions I took suspensions from my PhD, during NHS hospital mergers, and a year from the end of the Late phase, I resigned from my medical post in order to have both time and mental energy to complete this project.

I took the duty of confidentiality seriously and wherever possible I 'consented' my participants at the time of engagement. Generally, no one read the consent information,

but participants enjoyed the consent process which, over time, I understood to be an integral part of the art practice, just as it was for medicine.

The consent process

My consent process, agreed by the local NHS ethics committee, included a fifty-five page application form. The chair of the committee requested that I was accompanied by my Director of Studies, Professor Rod Bugg, as the work was unfamiliar to NHS staff. I had been asked to rewrite the application in simpler language and I also chose to use more pertinent and less controversial examples of art practice to illuminate my description. The NHS local ethics committee agreed that I would use the UAL consent form (which included the 3 pages of information about the project that were approved by the UAL ethics committee) and asked me to consent participants a week before the event. In practice I took informed written consent from people at the time as I had no idea which of the 2000 staff would attend and I could not consent all of this rapidly changing group of staff over the seven years. In all the events prior to March 2011, I had the full three pages of information about the research available. At *The Future is Social* workshops, March 2011, I modified the process in an impromptu event with café goers at Dulwich Pavilion Cafe, where I knew the staff well. I had only a blank piece of paper, which I asked participants to sign. I told them it was not only about trust but it was also an artwork. I added a verbal précis of the above information. All participants since March 2011 were consented by signing the blank paper after hearing the verbal précis. I discussed the changes with the Director of Research at South London Healthcare Trust, Dr Stephen Kegg, who agreed with the above practice. He also gave me permission to use video as the project had run smoothly.

Photography and video

Early on in the project I used a small format camera as I did not want to be intrusive. At that stage video had been forbidden by the hospital ethics committee. As confidence grew I used an SLR camera and added video.

Protecting others who were participating in the research

Aware that I was also encouraging others to undertake the potentially destabilising activity of finding their voices, I discussed the project with hospital counsellors. All participants involved in anything longer than a single one-off drawing event, for example the medical students who took Arts for Health and Medical Humanities Special or Career Study Modules with me, were informed about the free cognitive behaviour training programme MoodGYM, recommended by the Royal College of Psychiatrists (2014), Mindfulness (London Postgraduate Medical and Dental Education, 2014c) and about how to access counselling services through Occupational Health. Access to this type of service was a basic requirement for NHS research that involved staff or patient participants.

With respect to confidentiality, I considered removing everyone's name. I would certainly have done that if I was writing about their intimate lives, but I was not. I was writing about the objects they made and things that they did in a hospital department or corridor, or art gallery, lecture or seminar, which I considered to be performance. It seemed appropriate to acknowledge people, as this research used collaboration and socially engaged practice. I used each individual's first name and role, such as: Nic, Consultant Haematologist; Paddy, Porter and Jeanie, Arts Manager. It was both egalitarian and consistent with my day to day clinical practice. I knew many of the participants by first name alone. Most people would be able to identify themselves, but not others outside their own circle, except for very senior people, such as the CEO. I liked the idea that their contribution as creative individuals was acknowledged.

Professional practice: the conceptual foundation

Before beginning the PhD, I understood the opportunity this research might offer, when, during an extraordinary medical staff committee (2000), which was called at short notice, the consultant body refused to accept the ailing hospital's financial position. Managers were called to account by the consultant body (up to one hundred medical consultants). I explained to the chairman, before the meeting, that I would like to present something, if it felt the right thing to do. He agreed. I had done one or two participatory drawing events in the committee, during less stressful circumstances, which had been met with interest

and pleasure. I felt confident that my intervention could be beneficial for all participants, if the prevailing mood was for progress.

A moment came when most of the difficult things had been said about the past and current financial position. The chair introduced the new chief executive, a local ex-Human Resources manager, who apologised for the hospital's current financial situation (though he himself was not yet fully in post so could not be held responsible for it). The consultant body explained its dismay and asked for an explanation of the financial situation and reassurance that future problems would be openly discussed. This reassurance was given.

The main business of the meeting over, there was a need for a shift, and a sense of closure. I moved to the front and put a slide on the projector with the words '*Continuing Professional Development*' on it. I explained my implementation of the concept in pathology and emphasised its ease. All the Royal Colleges (Medicine, Obstetrics, Paediatrics, Pathology, Psychiatry, Surgery & Radiology) were participating. It was to be welcomed rather than feared or avoided. Instead of stopping for questions and discussion, I moved swiftly on to *Cleanse*. Firstly defining the word, then talking about the symbolic removal of dirt and filth, I explained about my MA² course in Drawing and used arts based language, contrasting my words and gestures with the medical scientific context. I talked about the removal of guilt and purification, displaying these words in a delicate italic font on the projector. I moved forward, first to the chief executive and chairman, squirting their outstretched hand with alcoholic hand cleansing gel as I went. It never occurred to me that anyone would try to avoid it. They did not. The desire to participate, and be cleansed, seemed over-whelming. A subtle shift of power relations in the meeting had occurred.

I weaved between the sixty or so people, dancing slowly between participants, squirting outstretched hands. The line of thick, clear fluid dribbled over them in globules and splattered down pin-striped trousers or hand tailored jackets. The extraordinary meeting had attracted the surgeons. The activity of hand-cleansing is most important in theatre,

² MA Drawing thesis *Not Only Challenging but also Therapeutic* Wimbledon College of Art (2001)

where it takes three minutes to wash and dry hands before putting on sterile gloves. The bottle of hand cleanser appeared as a relic.

My participants stopped feeling shocked, started laughing and catching the liquid. Jokes were made. I finished, moved to the front and thanked people for participating in my artwork. The room burst into spontaneous applause as if I had danced a particularly risky pas-de-deux. Perhaps I had.

Critical reflection on *Cleanse*

I perceived a huge anxiety within the hospital at a time of internal financial crisis (2000). There had been mismanagement and those responsible had left. I wanted to ameliorate the fears and believed that I had tools at my disposal. It would have been churlish not to try. *Cleanse* (2000), was held for a defined group of people who needed to consider priorities, possibly change directions, address a problem and adjust practice. The first opportunity arose in the extraordinary medical staff committee.

The combination of the financial problem, the ethical dilemma of the behaviour of those responsible and this '*extraordinary*' group meeting, enabled me to transform the act of cleansing, part of my routine clinical practice, into an art activity. Drawing, by my PhD definition, was taken to mean 'the act of making a mark or constructing a narrative with a simple tool or material that fits in the palm of one's hand'. Here the simple tool was my bottle of hand cleansing gel.

Early Phase of experimentation (2006-2008)

If there was one particular day that I had to claim as the first day of my PhD then I would cite the following. I was in my office in the Microbiology department, at six o'clock in the evening, when a cleaner came to my office. I complimented her on the finesse of her cleaning practice. She beamed. I explained that I was beginning an art project about smiling; she had a nice smile, could I possibly take her picture? I took two photos and showed her the images. She turned to me and said, 'You have a nice smile; shall I take your picture? A little surprised at this twist in the proceedings, I handed over the camera. She took my picture; we looked at it and smiled at each other again. I thanked her and we moved back to our respective jobs.



Figure 14. Pre-pilot exploratory stage: a smiling cleaner



Figure 15. Pre-pilot exploratory stage: a smiling artist-researcher

I showed these images at an educational presentation in the hospital, introducing the concept of empathy and claiming that this was the beginning of a research project. The audience, mainly of doctors were amused by the irony of a microbiologist producing an outbreak of smiling (our job is usually to prevent outbreaks).

From this small interaction between two women, the thesis and the first research question had developed. If I could produce a crop of smiles while staff engaged with each other, using craft skills, touch and the handling of materials, then I would have begun to answer

an important research question about how to develop empathic therapeutic interventions in difficult times.

Pilot event: 'Catching Empathy' Big Draw I, October 2007

Aim: To set up a participatory workshop in the hospital corridor, outside the canteen, to explore craft skills involving touch, that may have some direct or indirect relevance to clinical staff working in an environment where empathy was thought to be important.

Event Summary: A large number of staff enthusiastically participated in making small objects. They were able to express themselves creatively in the delicate 'hands on' making of the objects and also showed their communication skills with one another as they worked in groups. They not only looked as if they knew what they were doing but to my surprise, it felt as if they did. Participants came in teams and made teams of figures. They mirrored one another in their pleasure at exploring the craft skills of art, manipulation of the ceramic clay with their hands, evoking the use of materials when working on the body in medicine, for example, handling a needle and thread in order to stitch a wound. Drawing became a channel through which people were brought together in a way that facilitated an understanding of emotions and thoughts in an intimate yet open space.

In the first Pilot it was evident that participants made use of the idea of catching and containing using the fishing nets (the time and space for analysis) and brought in animal connections such as the little mouse (timidity), the seal and seahorse (floating free), horses (riding high but in contact), dog (your best friend). Another common theme was that of play time which allowed relaxation (the student who turned one of the *bocca* figures into a footballer) along with the idea of the team (which meant that the match could be won by participating and getting things right together).

Background: I set up an environment that resonated with aspects of my participants' lives: a domestic environment or harbour. I did this by having activities which included fishing for coloured plastic balls, lying on the ground, sitting or standing at a desk, working with their hands. There was a conscious intention to create an event, an unfolding tale or piece of theatre, within which my participants could perform by making objects in a space that was not only like their kitchen or the beach, but also had a resonance with their routine and emergency work, so that there could be an exchange between these two

mental spaces (Winnicott, 1971). The act of lying down within a hospital environment, rather than on a beach, would be a symbolic act of surrender of the body to the gaze of another.

Methods and Outcomes: Participation was by invitation, from the researcher to all staff with a hospital email address. The event was set up in a wide corridor near the west entrance of the hospital, outside the canteen. There were three drawing stations.

Stations: fishing for coloured plastic balls in an upturned plinth, using crabbing nets (chance and skill) bought in Penzance, Cornwall; lying on a twenty metre scroll of paper and being drawn around (taking the place of the patient i.e. horizontal on a bed or couch) and finally (the most popular by far), making 'people' (although all sorts of creatures and objects were made) by modelling 'ceramic clay', which was baked in the catering department ovens (at 130 degrees for 15 minutes). Postcards were provided for participants to record thoughts and feelings.

Participants were asked to make a small hole in their object, with a cocktail stick, the only modelling tool supplied. After 'firing', the sculptures (or *bocca*) were attached by tiny lengths of thread, to fishing net provided by workers from the Netting Sheds in Newlyn Harbour, Penzance. The twenty metres of netting was stretched across the corridor windows, providing a geometric framework, as well as a conceptual safety net. The act of hanging the objects on the net was the final participatory activity of the day.

The drawing station scroll of cartridge paper, unrolled on the floor to reveal the words, inspired by Gauss (2003):

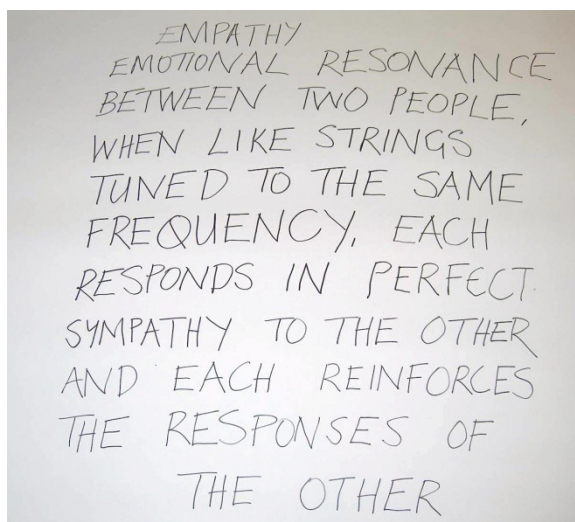


Figure 16. A poetic note about empathy on grounded paper scroll (1.5 x 10 m)

Participants were invited to lie down on the scroll and be drawn around, by me or Jeanie, the Arts Manager, who ran the Elixir³ Arts Programme. As participants became involved and lay down, space on the paper became filled with thin lines. They were also invited to lie down on the drawings of previous participants, so that an interlacing pattern of lines evolved, recording the rhythm and history of the event.

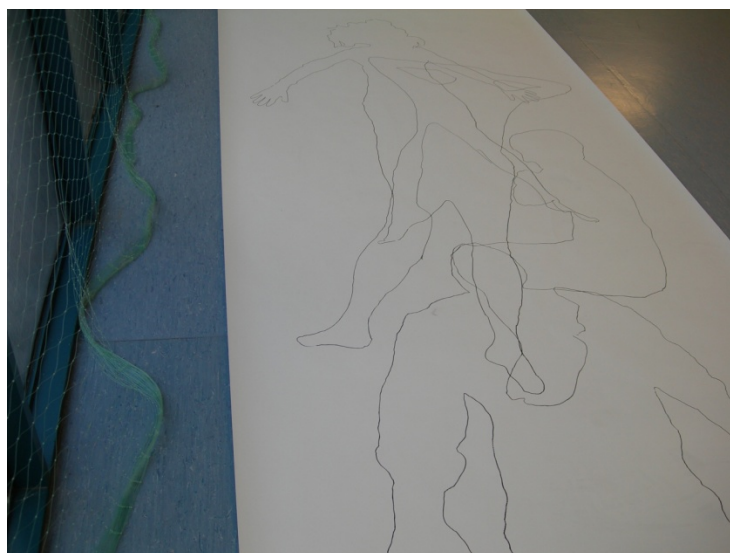


Figure 17. Drawings of outlines of participants

³ Elixir Arts was the Queen Elizabeth Hospital Arts Programme. Elixir Arts (which later became Verve Arts after the first merger to form SLHT and was renamed Arts Connect, following the second merger to form LGHT) developed a wide ranging programme of visual and performing arts. It was supported by a cross-Trust Arts committees. It was funded by charitable donation to the local hospitals involved.

A senior manager in the catering department baked the sculptures in batches. The baking allowed me to involve the catering department, where I was on good terms with a number of the long-term staff, thus engaging another level of multidisciplinary working.

Outcomes: Participation and Collaboration

The event started slowly. The first participant was a member of staff from a neighbouring NHS Trust that provided mental health and learning disability services. She was hesitant. She made a little mouse, which she laid carefully in the baking tray. The next couple of participants, seeing the mouse, made other animals, which they laid alongside the first creature.



Figure 18. The first ceramic clay *bocca* of a little mouse (2 x 2 x 1cm)

A mum came along with three children, who seized upon the opportunity to 'fish' for coloured balls in an upturned plinth.



Figure 19. Big Draw I: Children fishing for coloured plastic balls in an upturned plinth



Figure 20. Sea creatures, seal and sea horse (3 x 1 x 1 cm)

The event built up momentum until, by lunchtime, there was a large crowd around the sculpture table. There was a sense of the subversive becoming tangible, despite its transgressive nature.



Figure 21. *Big Draw* / Drawings of outlines of participants and children playing with fishing nets.

Nigel, consultant obstetrician, glances at the scene.

I made nothing but little figures, after the paper scroll was covered with multilayered drawings.



Figure 22. The first of many dice made over the years, with the first human figure (3 x 2 x 1 cm)

The process of attachment of the miniature sculptures to the fishing line was a different activity. People drifted up and were asked to help by tying them onto the fishing net. It

was as if they had forgotten that they were in a hospital and were behaving as if they were at home. This was a time when participants chatted freely. One junior doctor talked about the future and her personal and professional development. This was pastoral care but it had a more elegiac quality as we handled the tiny human and animal sculptures, tying them in place on the fishing net. The attachment of the *bocca* aided communication, people talking as their hands moved, almost independently.



Figure 23. *Big Draw I*: Snail attached to netting.

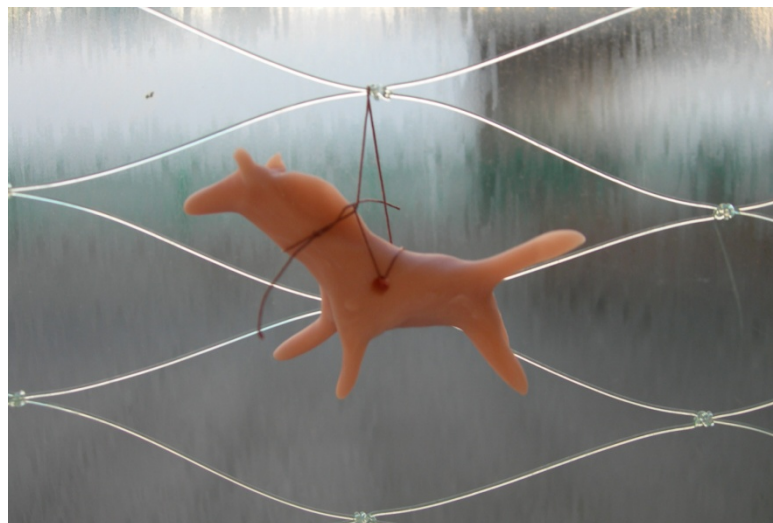


Figure 24. *Big Draw I*: Horse attached to netting.

Critical reflection and evaluation

Some of the sculptures made appeared to be objects within that chain of events, particularly the tiny, red men, one or two of the other figures and a monster with a big heart. The degree of involvement during the making process was evident in the excitement displayed by participants. This was not part of their routine work.

'My crazy monster has a BIG HEART' was a written comment from one of the participants, a foundation year one doctor. The vivid, exuberant, big hearted monster looked horrified & horrifying. Was she expressing the fascination and horror at what she saw on the wards? The junior doctor concerned had been attending sculpture classes at Morley College. She handled the material with confidence, clarity and happiness.



Figure 25. 'My crazy monster has a BIG HEART' made by a junior doctor (10 x 4 x 3 cm)

Animal pieces seemed such an important part of this first event. It took a while before I persuaded anyone to make a human figure. Our facility to share experiences with animals has long been recognised. Heinz Kohut gave an example of a dog greeting his or her beloved one after a separation and points out that:

...we know that there is a common denominator between our experiences and what the dog experiences...and we can begin to think in psychological terms, even if we should be inclined to stress that the differences between humans and animal experience must be great (Kohut, 1959, p 463).



Figure 26. *Bocca* Dog in ceramic clay (3 x 2 x 1cm)



Figure 27. Human Resources and Arts Managers attach *bocca*



Figure 28. *Big Draw I*: Junior doctor attaching sculptures of man, dog, dolphin and dice



Figure 29. Two nursing sisters chat and attach *bocca*

Marina Warner (2009) notes in *Animals in Fairy Tales*, that the anthropologist Claude Levi-Strauss talks about animals being good to think with, especially when exploring terror, violence, intimacy and injustice. Animals are used for testing medications and surgical treatments⁴ and as such may play an important role in the imaginations of many clinical staff.⁵

In *Empathy and the Novel* Suzanne Keen points out that:

...the literature and orature of most cultures feature talking animals and anthropomorphism...miniature figures such as Tolkein's hobbits and toys come to life [and] provoke empathetic reactions of readers who report ready identification with non human figures.' (Keen, 2007, p 68)

Object Relations theory is informative on the developmental role animals (real and imaginary) play in a child's growth and D. W. Winnicott (1971) talks of them as transitional objects in *Playing and Reality*.

One female participant made a woman with stilettos, on a mobile phone, with a child. She described the objects in that order and my impression was that her sympathies lay with the child rather than the mother. I think she felt sorry for the child, whom she portrayed with a sad face.

⁴ All individual research projects using animals require a licence to ensure the research cannot be done using non-animal methods, and that the minimum number of animals will be used. All individuals working with research animals must have a licence to ensure that they have the training, skills and experience to look after the animals properly. Government inspectors have unrestricted access. In 2004 alone, these inspectors - who are all qualified vets and doctors - made 2,682 visits to the 227 licensed animal facilities. Over half of these visits were unannounced (History of General Medical Council Press Office, 2012).

⁵ A shift away from animal experiments occurred between my time as a student in the 70s, and the 1980s when I observed animals treated with kindness and compassion in research laboratories.



Figure 30. *Big Draw I*: Sculptures of Mum with stiletto heels, mobile phone and child

Towards the end of the event a junior doctor, who had stayed a long period of time with his group, made a ball, complete with the octagonal patterns representing the leather stitching of a professional football. He carefully placed the ball close to the foot of one of the standing figures I had made in preparation for the event. 'I made him a football' he said. The scale was perfect. The junior doctor made a 'gift' for the mini-sculpture. This brings him into Lewis Hyde's (1979) sphere of *The Gift*, which explains how the creative spirit may transform the world.



Figure 31. Junior doctor claimed 'I made him a football' (8 x 4 x 2 cm)

Craig Richardson says of artist Christine Borland from her Living Subjects interview:

The past is important to her, there remains a layer of autobiographical import in her works, but to scratch away at these is to scratch at the self. The work has become increasingly exact; its precise aesthetic serves knowledge (Richardson, 2006, p 143).

In the *Big Draw* events, there was evidence of a bonding, when working with the pink clay, alongside trusted colleagues. When consultants brought their teams to participate, these relationships became more visible. The act of participating in a group not only made communication flourish between individuals, but people started to make things for each other and for the creatures, so that ideas were flowing back and forth.



Figure 32. The microbiology and pharmacy teams, making *bocca* together I



Figure 33. The microbiology and pharmacy teams, making *bocca* together II



Figure 34. *Big Draw I*: Medical student with his bocca figure, theatre staff in the background



Figure 35. A team or family of figures in ceramic clay (from 2-4 x 2-4 x 1 cm)

Consultants sat down with their junior colleagues and students, working side by side. Sometimes the consultant went for lunch and examined the bocca afterwards. Creative activities had become team-building exercises. One trainee made 'a rose for Dr Rose', a consultant neurologist, who came along. This haiku, written on one of the postcards, seemed to order her thoughts about disease in a rhythmical, playful way:

A rose for Dr Rose! We made a turtle called elephant.

Stroke vs. play dough? Hmm let me see



Figure 36. A rose for Dr Rose and a turtle called elephant (2.5 x 2.5 x 1cm)



Figure 37. Dr Rose shows off the bocca made by his team



Figure 38. Big Draw I: Hannah's family ponder the tiny figures hanging on the fishing net

A recently bereaved family talked to me about my project and followed by a discussion of their bereavement. The conversation then opened up: their individual experiences in the British Museum and in the Mortuary and Pathology departments of the hospital, where they had worked. The discussions helped them in their encounter with the hospital. We

talked about empathy in the context of the *Elgin marbles* in the British Museum. The daughter, who had lost her mother, drew upon her understanding of the sculptures. She spoke of Greek versus Roman sculpture, how the Greeks expressed empathy at a level beyond the Romans, whom they considered to be ‘mere technicians’.

In her opinion the Parthenon sculptures contrasted with the ‘depressing effects of the Emperor’s army’, the terracotta sculptures from ancient China, which had just been on display at the British Museum. This discussion drew upon pre-existing knowledge, which appeared to become a therapeutic tool. I wondered if I was providing a safety net for important feelings and a space for quiet reflection, similar to the space I found in my own studio.

Six months later, I visited Hannah at the British Museum and she took me round the Greek and Roman galleries, explaining stories of the gods’ loves, rivalries and family squabbles. The notion of the *agon*, referred to by Bleakley and Marshall (Chapter One), came to life. The battles of the gods became closer to the problems in the Trust.



Figure 39. Artist-researcher taken by a member of Hannah’s family



Figure 40. Artist-researcher with Hannah and her brother, taken by her father

Impressions and Reflections

From the experimental data derived from *Big Draw I* it became apparent that animals were very strongly linked with empathy in peoples' minds. They wished to make and comment about them, suggesting that they may have identified with them and perhaps, 'changed places in fancy' for a few moments during their busy hospital day.

The photographs of the event show the staff working individually and together, with evident pleasure, to produce an installation of their hand crafted work on a net suspended across the windows of the hospital corridor outside the canteen. The event established that it was possible to get a large number of diverse staff from many departments to work together. The photographs demonstrated craft skills, including the surgical requirement to tie knots. The final installation catalysed a discussion of mortality and artefacts from ancient Greece. This way of working augmented these skills through hands on manipulation of material and allowed exploration of emotions and thoughts through discussions around pets, chance and mortality.

The objects I chose to illustrate were the ones that struck a particular chord with me and are a measure of the influence of the staff upon the project. The tiny snail tied to the safety net was a poignant reminder of the slowness of change and the difficulty of making progress.

Big Draw II, Locating Empathy: forms of animals and double-blind drawing, October 2008

Aim: To investigate an affectionate parody of the double-blind controlled trial by asking staff to sit or lie down and try drawing animals from memory with both hands at the same time, eyes closed.

Event summary: The staff continued to display an interest in animals, particularly their pets. They experimented with drawing positions, taking the exercise very seriously. They carefully and thoughtfully performed and analysed the blind-drawing which they did with both hands (some of them roaring with laughter when they saw what they had done). Clinical skills, including the ability to laugh at oneself and to take lightly but seriously the distress of others, were apparent.

The second pilot showed that double-blind drawing (DBD), was one of the fundamental practices of the PhD. The work addressed the neuroscientific phenomenon of the polarisation of function in the two sides of the brain and distilled a mixture of scientific and medical trainings through a grounding in art practice. The Chief Executive actively encouraged participation, ensuring that the event was widely advertised and staff were reassured about attending.

The audience of participants acted; the hospital chaplain bowed down as if Muslim (Anglican but from a multi-faith community), the cello-playing junior doctor noted she felt freedom, the doctors from Dermatology sat bolt-upright attending hard and the training manager felt as if his attention was shifting from one side of his brain to the other.

The attention on Double-Blind Drawing was successfully focused on animals, confirming this combination of methods for the next phase.

Background: Avis Newman suggested that drawing offered the most direct access to the intimate workings of the artist's mind:

I have always understood drawing to be, in essence, the materialisation of a continually mutable process, the movements, rhythms, and partially comprehended ruminations of the mind: the operations of thought (Kovats, 2006, p 100).

Newman describes the act of drawing as a way of casting our thoughts into the visual domain, with the opportunity to cast and recast. By asking my participants to draw with

both hands at the same time, I receive a dual reflection from them, an impression from both hemispheres of the brain, making this a rich and life-like experience for my participants, medicine being an activity that requires constant use of both hands - when taking blood, examining a patient or disposing of the waste at the end of a procedure.

Newman talks specifically about the essence of drawing:

I am interested in the way the interconnectedness between inscription and representation is grounded in the primitive body. I am not speaking of the language of depiction and representation, but of what constitutes the mental energy of engagement that is so evident in drawing: how the markers of an action translate the murmurings of the mind. [Cy]Twombly conveys the stories of the world by means of a graphism that is grounded in corporeal acts – his calligraphic scrawls and scribbles, rhythmic scratches and suggestions of child-like acts of inscribing evidence not only the gestural expression of the body but also the body of the work. (Newman, 2003, p 231)

This type of drawing was an affectionate parody of the double-blind controlled trial, the most reliable form of research in medical circles. In such experiments, one group of subjects receives the real thing, while the other half receives something that looks and feels like the real thing but is actually a placebo. None of the individuals know whether they are getting the real treatment or not (hence they are 'blind'). The researchers are also kept in the dark, making it a double-blind experiment (Misra, 2012).

The physical action of mirroring and the psychological process of imagining the situation of the other are both important in the exploration of empathy. The double-blind drawing approach, lying on the floor in a public hospital corridor, with eyes closed, allowed an engagement with a physical process that was connected to internal images and symbols, through the sense of touch, to a space that is both internally located and attached to the external world and the socially engaged space. This was an activity that might encourage disinhibition.

Big Draw II featured cello playing, which encouraged participants to relax into the drawing with their eyes closed despite being in the hospital community. Rebecca Horn's *Pencil Mask* (1972) made repetitive drawing which operated as a compulsive movement. She also produced a kinetic sculpture which acted as a cello playing 'machine', shown at the Hayward Gallery (2005). The haunting, poetic but slightly humorous nature of these

works impressed me greatly and encouraged me to introduce the cello as a piece of drawing apparatus. Horn spent long periods in hospital as a child (Kent et. al. 2007).

I was interested in Claude Heath's blind drawing. He drew plants double-blind, with both hands, the paper under the table so that he could not see it, in Wimbledon College of Art's project space, where he did a residency in the late 1990s. He asserts that drawing from touch carries a quite different body of knowledge from drawing by eye (Kingston, 2003). Later I discovered the 1960s New York subway drawings of William Anastasi. He described his technique as holding two pencils dart-like on the pad surface over the course of subway rides, whilst breathing out in a meditative way (Massara, 2013). This technique is close to the origin of my ideas, responding to the environment through touch, picking up the vagaries of the journey.

Method:

I used colour photographs of animals, as a way of enticing my participants into the field of drawing and helping them to consider empathy in an environment that was outside the hospital, and yet germane to their practice with the human body.

The 'zone for drawing' had twenty-six photographs of animals, from Aardvark to Zebra, in alphabetical order, tacked to the windows of the long wide corridor and a 'private area for more intimate drawing activities', a screen, behind which were scatter cushions and a yoga mat, like a child's play den. I asked participants to select an animal that captured their interest - their own pet or an animal that fascinated them for some reason, one that they could identify, or feel at home with, in some way.

Finally, my cello, lying on its side on a long thin drawing scroll, played by me or my registrar, who was a competent cellist. The bowing was considered to be an act of drawing.

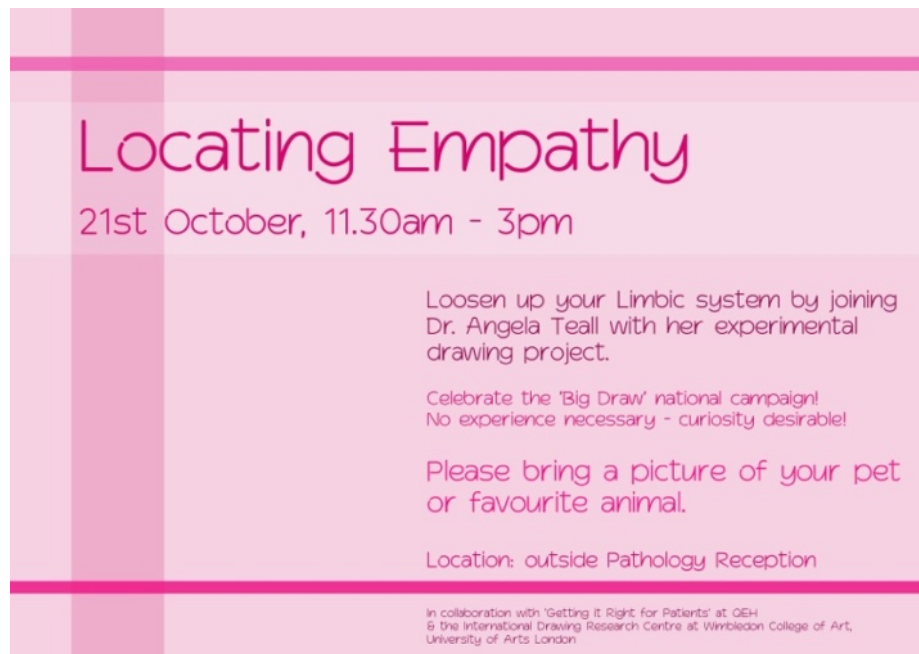


Figure 41. *Big Draw II: Locating Empathy* poster

Empathy: I suggest that this was a type of 'knowing another creature or individual's internal state, including his or her (imagined) thoughts and feelings.' (Bateson, 2009, p 4)

Double-blind (bi-manual) drawing: I asked each participant to take two pens or pencils and two pieces of paper, taped down during drawing. Participants were asked to look at or think about the chosen animal and then close the eyes (or look away), and draw the animal with both hands. If this was too complicated, I asked them to start with one hand and then progress to using both hands. They were asked to record which drawing was done with dominant hand and which with the non-dominant hand and also to record the feelings and experiences about the drawing, noting which was more difficult and which gave a greater sense of freedom.

Enthusiastic or confident drawers were asked if they would like to try what I called 'A' level, (advanced or accelerated drawing). They were asked to repeat the drawing process, still with eyes closed but with greater contact with the ground, either lying down to draw or gently resting the head on the ground to draw with both hands. I provided a yoga mat, head cushion and a screen to shield them from the gaze of people wandering along the corridor, next to the hospital gallery, where the event was taking place. This exercise replaced lying down and being drawn around in the pilot study.

Outcomes



Figure 42. *Big Draw II*: Tristan, hospital chaplain, kneeling for art and double-blind drawing

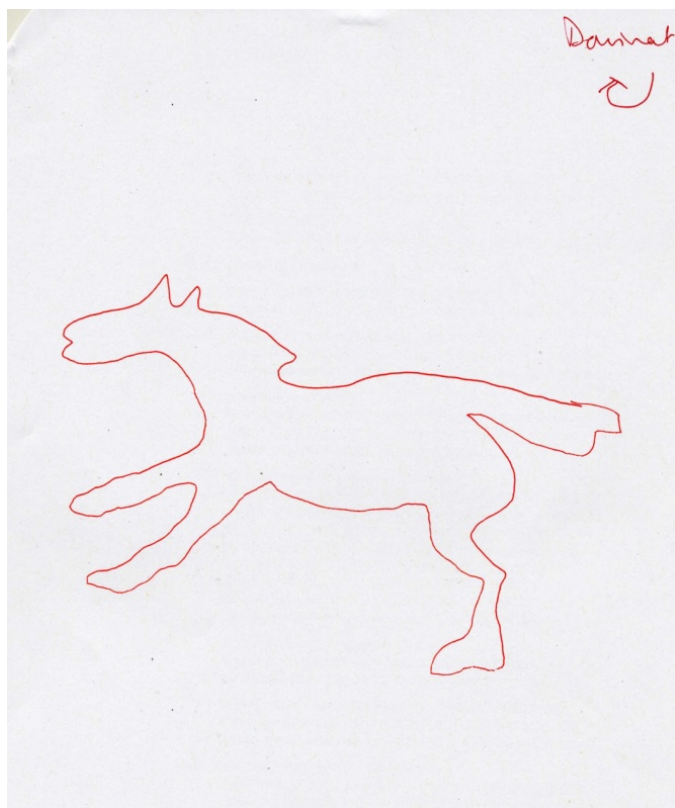


Figure 43. *Big Draw II*: Horse, by arts manager, Jeanie, and her 'memories of drawing in childhood'

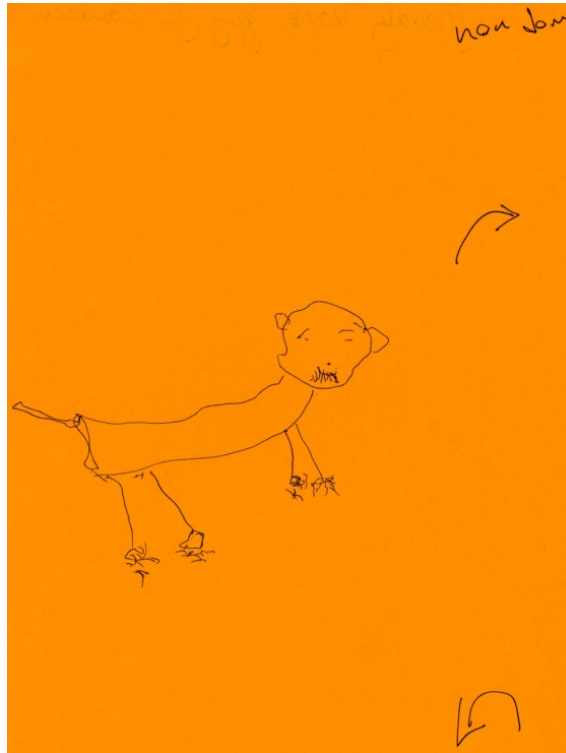


Figure 44. Big Draw II: A cat, drawn with participant's non-dominant hand and with eyes closed

The event functioned as a therapeutic intervention. Several participants reported how much they had enjoyed the exercise or commented how pleasant it was to have musical sounds whilst drawing. The calming effect of the sounds of open strings (single notes in random harmonic sequences) from the cello was visible in the changes of the postures and gestures of the participants, which became more relaxed.



Figure 45. Big Draw II: West entrance - cello, drawings & advanced drawing space



Figure 46. Big Draw II: Anna, consultant dermatologist & her team 'double-blind drawing'

A couple of participants appeared to be using the event as a way of moving on or making progress. One member of the Pathology staff, Indra, had even brought a photograph of his dog to draw. I knew the dog from mobile phone photographs he had shown me in recent months. Indra's eyes were moist, as he told me a story about his life, on the day of the drawing event. He was one of several staff who brought photographs of their pets and family.



Figure 47. Jester, Indra's dog, (photograph supplied by the participant)

The event worked well as collaboration with staff I had worked with for many years. Sarah, Consultant Haematologist, agreed to draw, double-blind. 'I'll consent to anything,' she added kindly, saying that her patients contributed so much to her own PhD.



Figure 48. Big Draw II: Sara, consultant Haematologist, DBD behind a privacy screen

For the participants the activity of double-blind drawing created amusement and many laughed with hilarity when they opened their eyes. There were some very serious comments from people noting how the focus of each of the two drawings (produced with left and right hands, eyes closed) was different. For example a training manager, who had done a lot of good developmental work with medical staff, said:

I actually felt as if I could feel my concentration moving across the two hemispheres of my brain. The dominant side in the first drawing clearly took the lead. In the second drawing, it felt as though the less-dominant side was to the fore. I didn't feel simply as though I was concentrating more on that aspect; it was as if the focus was altogether different. That said, the dominant side in the second exercise, despite the lack of apparent focus, actually produced a better rendition of a horse!



Figure 49. Big Draw II: Training manager, with a particular interest in staff development

The second participant, a junior doctor, did not comment on the link between two sides but identified a different emotional expression between dominant and non-dominant hands. During a series of drawings of three animals; gorilla, kangaroo and giraffe, she makes the following comments about the images produced by her non- dominant hand:

Gorilla - Drawing with the non-dominant hand is less 'accurate' technically. The lines didn't go where they were meant to and are messier. However this picture looks more like the emotion of a gorilla – it looks more powerful and impressive/imposing.



Figure 50. Gorilla (dominant hand)



Figure 51. Gorilla (non-dominant hand)

Giraffe - Initially I drew with my eyes closed. I found it difficult to remember which direction to draw. On the reverse I tried drawing with my eyes open but looking away (although I cheated) but I think I was worried about producing a 'bad' piece with my eyes open. With my eyes shut I felt less judgemental about my efforts. Again there is more of the tremulous character of the giraffe captured with my non-dominant hand.



Figure 52. Giraffe (dominant hand)



Figure 53. Giraffe (non-dominant hand)



Figure 54. Kangaroo (non-dominant hand)



Figure 55. Kangaroo (dominant hand)

Kangaroo - I chose to draw the kangaroo because I like the way they move. Having now had some more practice at this technique I feel the results look better. Again my non-dominant hand captured the energy of the animal and had more of a feeling of movement than my dominant hand. However now that I am further along with this method of drawing, my non-dominant hand has actually become better and I can produce better results. I don't know whether this means I have lost some of the instinctiveness of the drawing. I think my feelings of the non-dominant hand are slightly biased by the colours used (green ink and orange or green paper, rather than pencil or various coloured inks on white paper) as they are typically Australian, and this adds to the impact of the image. I enjoyed the experience of drawing in clockwise and anticlockwise directions simultaneously but I'm not sure why. I think it stopped me thinking about what I was doing so much.

Reflections on Both Pilot Events in Chapter Four

The research practice in Chapter Four began with an exchange of smiles between two very different working women. The smile related to the quality of work performed by one and admired by the other. From this humble starting point, the research used experimental drawing methods which were taken up with enthusiasm by the staff. The activities were chosen for their tangential relevance to the observational, tactile and communicative craft skills required in medicine. The thrust of the practice was driven by action research, repeating cycles of practice which responded to the ideas of participants in addition to the intuitions of the artist-researcher.

The act of plucking a coloured ball from an upturned plinth with fishing net was child's play, bringing a smile to the lips of participants. The bocca of pink ceramic people, fishes, dogs, horses, birds, flowers and dice might have indicated the world of nature that we inhabit, the living arena in which patients develop diseases and turn to the staff for help. The experiences with the bocca animals appeared to have such a powerful effect upon me and my participants that I decided to include animals as a subject in subsequent events. The drawings in coloured pen or pencil on coloured paper in orange, yellow, white and green hung out on washing line, reinforcing my theme of cleansing the Trust, whilst also giving people a space to play.

From these simple exercises I learned that my experiments had an impact on staff; my participants played, thought and felt emotion and, above all, they smiled. The challenge

for the next round of research was to simplify these exercises further in order to pin down the relevance of thinking through the being of an animal or other expression of nature. I wanted to understand the role of the cello, which was popular with participants, and to explore further the position of those brave enough to adopt recumbent positions.

The *Big Draw* pilot events confirmed that a socially engaged practice and a 'gift' economy, where both the artist and the participants gave their time and expertise. The staff response to events suggested that thinking through drawing could reveal something about the way empathy was practised in a hospital environment.

These opportunities to make drawings and *bocca* augmented the craft skills of medicine using rhythm, humour, tactile understanding and lack of intimidation.

Chapter Five:

Experiments for grounding and focusing staff in the newly formed South London Healthcare Trust

Rainer Maria Rilke said that he came to understand 'the position of the poet, his place and effect within time' only when he sailed in a ship whose powerful rowers counted aloud, and whose singer would send 'a series of long floating sounds' out over the water.

Elaine Scarry, *On Beauty and Being Just* (1999, p105)

Summary of Chapter Five

Chapter Five examines the drawing events, talks and discussions that occurred in the run up to the merger of three South East London hospitals: Queen Elizabeth Hospital (QEH) Woolwich, Queen Mary's Hospital (QMH) Sidcup and Princess Royal University Hospital (PRUH) Bromley to form the new organisation, South London Healthcare Trust (SLHT). The process began in April 2009. Changes did not begin to bite until the October of the same year. This chapter tracks the two years following the merger.

The experimental drawing events built on the experiences from the Pilot Phase of my research. Activities using both hands, ideally at the same time, lying down, drawing animals and playing the cello. Wherever possible people closed their eyes, which often proved challenging or hilarious but reassuring.

My research question in Chapter Five was whether drawing could shift the rhythms and responses of the staff by grounding and focusing them. A related question was whether these practices could produce some of the effects of talking therapies, but without actually using this technique on a one-to-one basis.

In the first event of this phase I broadened the activity of making animals with ceramic clay to include a mythical creature or invented beast and considered the role that animals play in our imaginations and the notion of the human body as animal. I focused on the tasks of modelling and drawing but giving simpler information about empathy, describing it as

'Entering the private world of someone else and becoming thoroughly at home there.' (Rogers, 1980, p 142). I later realised that feeling 'thoroughly at home' in someone else's world was either impossible, undesirable or both.

By December 2008 the hospital *Elixir* gallery was fully operational. Staff loved the exhibitions, which changed every few months, including the first *Big Draw* exhibition (2009).

From October 2009 onwards the three hospitals of the Trust (SLHT) were expected to function as a single unit. Managers and lead clinicians had been appointed across the Trust. Sadly, confusion also began at this point, as changes happened very fast and the new leaders had little time to get to know those they were leading (and vice versa) before changes had to be implemented in order to address the financial and clinical issues (Health Services Journal, 2012). The drawings from our 2009 Elixir gallery show were re-exhibited in a gallery at Wimbledon College of Art (UAL), a move that was greeted with interest and excitement by many staff, as it was evidence for the seriousness of our enterprise.

In the event and exhibition of October 2010, I engaged with senior staff of the Trust and arranged for the event to coincide with Infection Prevention week. My work as a Microbiologist, to whom the practice of cleansing was fundamental, led me to consider the act of hand cleansing as art practice. It was a bimanual process, consistent with my understanding that the right hand was directed by the left brain hemisphere (and vice-versa for the other hand-brain). I became more political, including my roles as artist and Microbiologist in a single event in 2009, thus highlighting my dual status. I was also interested in revisiting the act of double-blind drawing lying down, out in the open, rather than hidden behind screens.

Serious questions of performance were being addressed by the Trust. We had to keep working and maintain a high standard during the merger. I tried to create a practice that would have relevance both to my research questions about drawing, empathy and socially engaged practice and to my participants' questions about how they would, at worst, survive and, at best, thrive in a rapidly changing environment. I proceeded on the basis that empathy was important to their development as colleagues and practitioners, but I did not

underestimate the difficulty of the task. The solidarity of the support I received in this phase enabled me to have the confidence to carry on.

I asked myself how I could minimise disruption in the hospital in order to enable my research to progress, whilst also maximising my engagement with difficult questions in the Trust and in art practice. I knew that I needed others to help me. I wanted to encourage them to make drawings using some of the gestures and cognitions of our day to day work, both clinically and managerially. As we adjusted to the shifting organisational structure and our own feelings of confusion, we addressed the failures in our clinical, managerial and financial performance. Despite this, I gained insight into how to sustain and develop clinical practice, using drawing and empathy.

The background to the formation of South London Healthcare Trust (SLHT) in April 2009 (October 2008-October 2009)

The new organisation of South London Healthcare Trust was formed as noted above. Lewisham Hospital, a Foundation Trust, was to have formed one of the hubs with the Queen Elizabeth Hospital but declined to join SLHT. Our Chief Executive (who was also a doctor) was appointed by April 2009. Two of the merging Trusts had Private Finance Initiative status. This meant that they were expensive to run (the premises were run by private organisations, with whom we had long term contracts) and already heavily in debt when compared with the neighbouring Foundation Trust at Lewisham Hospital. The position was challenging. Chris, the new Chief Executive was delighted with the potential to open doors using art, creating opportunities for 'thinking outside the box' and giving the staff, apprehensive about the merger, interesting educational opportunities. ('Securing sustainable NHS services' consultation on the Trust Special Administrator's draft report for South London Healthcare NHS Trust and the NHS in south east London, 2013).

***Empathy Under the Microscope* presentations, exhibitions and events (2009)**

Presentation at the Association of Medical Humanities Conference, Durham University

The aim of this presentation was to focus on the psychoanalytic, neuroscientific and biosemiotic aspects of empathy, as already explained in my approach to the research, and

to explore the art works that had been made in relation to some of the questions I was asking, giving specific examples of the Big Draw experiments. I used art practice for 'simulation' of clinical practice.

Christine Borland's *simFamily* and other works from her show *Practice* described in Chapter One and some of Bobby Baker's performances (discussed in the next section) were presented.

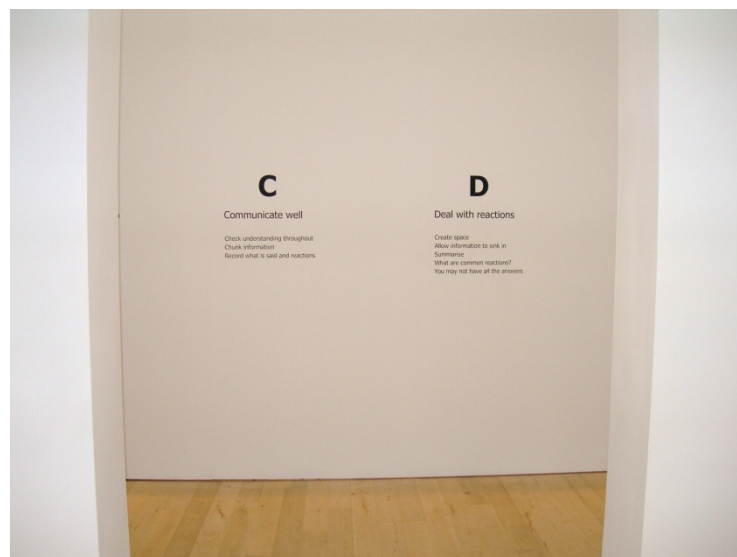


Figure 56. *ABCDE...* Christine Borland (2007) in *With Practice*, Newlyn Art Gallery

At the conference, I concentrated on the difference between natural, or primitive (early), and mature empathy, as I hoped to encourage the former to develop into the latter with my events. In its natural, form the empathic response originates in an automatically triggered, affect-matching induction, generating the contagion and expression of a similar feeling state (Aragno, 2008a, p 727). This automatic response, present from very early in life, is gradually modified by experience so that mature empathy can be used beneficially in a clinical environment. Aragno explained:

Mature clinical empathy...sharpens sensibilities to unconscious dynamics that may produce even confrontational interventions, yet fitting therapeutic responses at that moment. (Aragno, 2008a, p 715)

Conference Reflections: Christine Borland, present in the audience, asked, 'Where is the art?' highlighting the problematic issues raised by art practice in a medical context, and vice versa. The dialogue between art and medicine became the research question for Chapter Six.

At the time I was uncertain where and how the practice of art was located within this complex arena. I gradually built up a body of work by staff, including the *bocca* and drawings, which showed the practice engaging with the Trust at moments when empathy was required. It was not until Spring 2011 (beginning of Chapter Six) that I realised how important were the subtle shifts of staff behaviour and gradually increasing confidence with art practice that occurred in relation to the events.

Aim for Experimental Work: This was to ground and focus staff, with respect to empathy, at a time of change. A presentation about clinical and art issues for students and staff preceded the *Big Draw* event *Empathy Under the Microscope* (2009).

Events' Summary: Following a provocative lecture, including Borland's medical imagery in a gallery context (2007), O'Reilly, cradling a pig carcass (2005), and a giant Mexican wave (Baker, 2006); provocative objects and mythical creatures were produced. The boldness of ideas introduced by the artists above was matched by a boldness of production by participants. These included a ceramic eye with tear-drop, from a multi-disciplinary cancer meeting, an upside down uterus, a pink fleshy perineum, bronzed Pegasus flying, a drawing performance by the Director of Infection Prevention and a hand-cleansing experiment with her assistant and finally a *bocca* cat from the Chief Executive. The importance of touch as a means of communication was emphasised by the performances and process of production of objects.

These activities progressed the research to a new level whereby the art began to have a dialogue with healthcare delivery. The staff were engaged beyond the boundaries of their clinical practice in a way that was sustaining for them, their work and the Trust itself. The harmonic sounds of the cello, echoing down the corridor to passing traffic including waste

bin on wheels, beds and concealment trollies, ensured that the porters and others in the background of healthcare were included.

During this Middle Phase, drawing shifted the rhythms and responses of the staff by expecting them to engage seriously with art practice. They were given tools that connected both with art and medicine, enabling them to undertake this task. These devices focused them.

Central to this event was the suggestion that art was a place for being provocative. The cello was helpful in its *Fluxus* drone-like manner, attracting passing staff, including the porters. The role of mindfulness was seen in a poem, constructed from participants' comments, reflecting on the activities.

This event confirmed the position of animals in the research and the way that they engaged participants including Tim the chef.

Clinical and Art practice presentation (October 2009)

My presentation (immediately before a Cardiology talk about emergency work) was a brief summary of the last two *Big Draws* (2007 & 2008) interspersed with photographs of artworks by Bobby Baker, wearing bread antlers and a heart, made of bread, positioned against her chest wall. Her performances and drawings included humorous insights into Baker's own life, including her psychological traumas, her triumphs and her continuing interest in therapeutic outcomes.



Figure 57. *Cook Dems* © Bobby Baker and Andrew Whittuck (1999)

Bobby Baker (2007) put a pea on the psychoanalytic couch (a brilliant adjunct to explaining projective identification) in order make it clear that she was both amused and frustrated by the training material available in the United States.



Figure 58. Bobby Baker analyses a pea, Barbican (2006)

She also organised a Mexican wave performance by 5000 peas, each individually suspended from behind the proscenium of the Barbican's main stage (Baker, 2006). Her focus on the peas drew attention to the many individual 'peas' who make up any large organisation. There were approaching 5000 people working in the hospitals' Trust at the time I gave the presentation.

I described the disturbing performance of Kira O'Reilly (2005), a naked woman embracing a deceased pig, highlighting the importance she placed on nature and caring behaviour in unusual and vulnerable situations.



Figure 59. Kira O'Reilly (2005) embracing a pig, Home Salon, Camberwell

I showed text and sound based work by Christine Borland (2007) about medical students exploring their communications skills, including misunderstandings arising during programmed clinical questioning, recommended by the London Deanery (2011). The talk included the psychoanalytic theories of empathy, discussed in Chapter Two.

The chair, Nic, a Consultant Haematologist and supporter of my work, claimed that it was 'an art, translating empathy formulas into practice.' The importance of touch was a recurrent theme. It was considered empathic to lightly touch a patient or colleague during conversation about a serious subject. Brendan, a Palliative Care consultant, recounted a

patient asking him 'Why do you people always do that?' Both the consultants and the patient were referring to a feeling that an empathic gesture could not be scripted in a guideline.

Nicolas Bourriaud, in *Relational Aesthetics* said:

A work of art has a quality that sets it apart from other things produced by human activities. This quality is its (relative) social transparency, if a work of art is successful, it will invariably set its sights beyond its mere presence in space: it will be open to dialogue, discussion, and that form of inter-human negotiation that Marcel Duchamp called 'the coefficient of art,' which is a temporal process, being played out here and now. (Bourriaud, 1998, p 41)

Like some of the events described by Bourriaud (1998), my presentations were choreographed and intended to be for the benefit of the participants (and indirectly the patient). Discussions included exploration of issues around causation, in order to treat patients, and meaning, relevant for the welfare of doctors who look after them, as tackled by Alan Bleakley in *Patient-Centred Medicine in Transition: the heart of the matter*. He expressed concern about:

The persistent phenomenon of poor self-care amongst doctors, perhaps as a symptom of lack of psychological acumen, which includes relatively high incidences of suicide, depression, and substance and alcohol abuse. (Bleakley, 2014b, p5)

In medicine we document, often by hand, the ephemeral life and death of our patients. Our observational and interpretative skills, our word, and the trust the patient puts in us are all important. There is a desire for accuracy. Art practice hones those skills, maintaining a critical distance, helping the staff and patients. Maintaining a sense of community during life-long learning is important, akin to forms of socially engaged practice that go 'well beyond the institutional confines of the gallery or museum.' (Kester, 2004, p 1)

Methods and Outcomes: *Big Draw* lecture, exhibitions and event *Empathy Under the Microscope* (October 2009)

This activity coincided with the end of the transition period (April-October 2009). Managerial arrangements for 'change development' were behind schedule. Despite support from the

chief executive, the arts manager and arts programme were under threat of redundancy and cuts so the event was arranged with careful thought. A number of senior managers had just been made redundant and staff were feeling sensitive. Colleagues, interested in the research, were sent a personal invitation.

There was a sense of excitement about the project. Showing a slide review of three *Big Draw* events to medical staff (students, trainees and consultants) brought my research into focus and created a sense of social potential. The references to an inner world of complex sensations touching on identity, notions of individual and collective bodies, the possibility of crossing traditional boundaries between art and science, madness and therapy, the poetic and the real, appealed to the audience and participants. It was a time of risk for the Trust. Stakes were high as massive changes were required. Staff knew this and were prepared to experiment.

At the events participants were asked to select a creature, a mythical beast or another subject from nature that captured their interest: one that they identified and felt at home with in some way, which they could sketch with coloured pens or pencils on white postcards or make a *bocca* with a small ball of pink ceramic clay, as before.



Figure 60. *Big Draw* (2009) Ayo, a microbiology registrar, draws a beast

One participant, defined empathy in the following way: 'empathy is being able to understand how someone feels and communicate that to them through different mediums.' My

response to this was to wonder whether they meant a sense of movement between past, present and a possible future. Using different media, for example, gesture (a type of drawing) and speech, one might be able to connect with different times or ways of thinking in someone's life. I thought about instances where doctors had reassured me. I concluded that a well-rehearsed phrase and an impromptu, gesture or glance might have been the combination I both recalled and practiced myself.

The palliative care consultant, Brendan, said, 'It's great to see someone making connections across art and medicine. We interact with patients/families/cares daily and at all levels – but to do the job well remains an art. Science can only teach us so much; the rest is down to us being open'.



Figure 61. *Big Draw* (2009) Daughter of ITU nurse, hospital photographer and arts manager

One gynaecologist left the drawing event to go to a multi-disciplinary cancer meeting with the rest of his team. One of the junior doctors had not had time to make a sculpture so she took the ceramic clay away to the meeting and came back with a small sculpture of an eye with a tear-drop, having, perhaps 'put herself in the shoes of a patient' a little more closely.

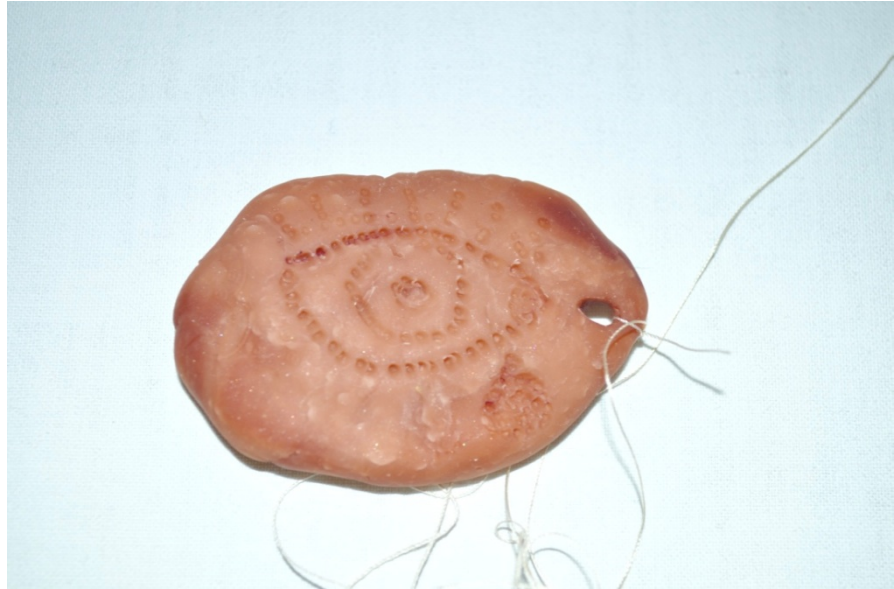


Figure 62. Ceramic clay eye with tear-drop, made in the cancer meeting

John, the consultant in charge of the team, said to me, 'I draw to explain the details of a hysterectomy operation to the patient. This is not one of my best drawings of a uterus as I need to be drawing upside down, with a woman with cancer in front of me, in order to do that.' John was explaining that in the presence of a patient, for whom he felt compassion, his drawing skills were honed.

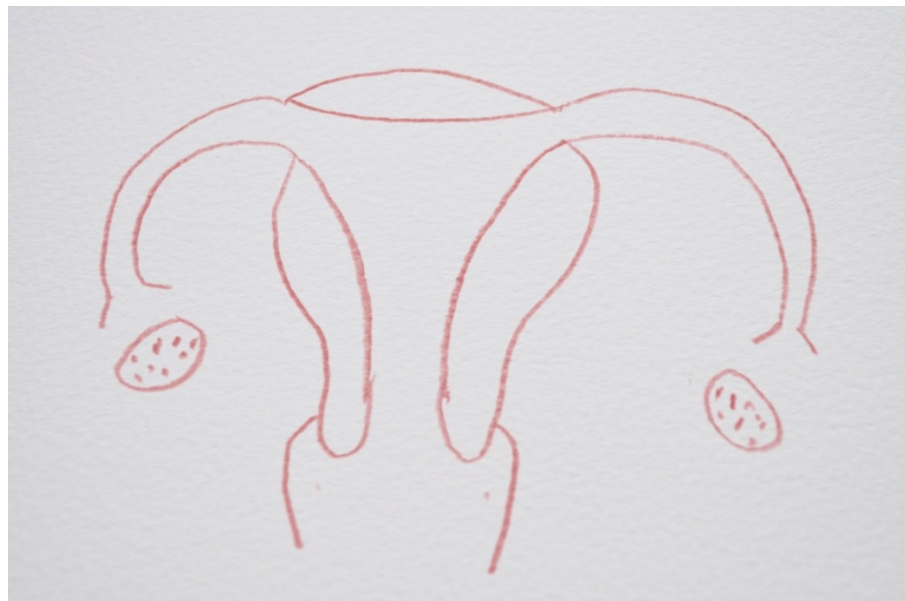


Figure 63. *Big Draw* (2009) Uterus drawn by John, a Gynaecologist

Senior staff may have projected themselves into the situation of their patients, who wanted doctors and nurses to understand how they felt. I noticed that when consultants brought their junior doctors along, all experimented more freely. Maybe it was more relaxing or a better opportunity to educate their juniors. Either way, it was a valuable part of training.

Changing the engagement with animals to one which included mythical creatures was coincident with staff expressing themselves more imaginatively about the vagaries of the clinical process. For example, consultant gynaecologist John, felt he had to draw upside down to feel sympathy properly and the 'provocative object' required kneeling.

Making an object referred to as 'provocative'

The group of medical students arrived together saying, 'We've come to participate but we only have 5-10 minutes before our teaching. Is that ok?' I gave each of the students, two men and two women, a small ball of ceramic clay, a sheet of instructions and explained that I was interested in the body and empathy. I left them to it and carried on working on a tiny hand I was making.

They stopped talking and started rolling the clay. One of the young women began, standing bent over the table. She made with both hands at once, fashioning a roundish flat object, concentrating with all the application of a student in her final year of medical training. Eventually she became so absorbed that she knelt, in order to make more effectively. There were only a few chairs and she appeared not to need one. By kneeling rather than sitting, the distance between her face, her hands and the object she was working on was similar to the working distance between a doctor and a patient, when a woman has an examination in the lithotomy position¹.

¹ Lithotomy position: Position in which the patient is on their back with the hips and knees flexed and the thighs apart. The position is often used for vaginal examinations and childbirth. www.medterms.com [Accessed 1st February 2011]



Figure 64. Medical student fashions a perineum as 'provocative object'

She did not say anything about what she was thinking, appearing engrossed in the task. It felt as if she, the maker, was saving someone's life as she modelled. Finishing the object, she handed it to me very carefully, in cupped hands. I placed it very gently in the baking tray, smiled, and said thank you very much. The skin-like surface of the object was less than a millimetre thick in parts and was very delicate and pliable in its unbaked state. The form was of an anatomically detailed vulva. Whether it was about medicine, eroticism or something else, I did not ask. All she said, as she gently handed it to me was, 'It's provocative.'



Figure 65. *Big Draw* (2009) *Bocca* 'provocative object' (5 x 4 x 0.5 cm)

In order to make the object, the student had mentally put herself in the position of the examining doctor. This may have been a physical process for her as well as one that she recognised as psychological, acknowledging the potentially provocative nature of her object as she handed it to me, which exuded a sensual pleasure in the making of it, with its delicately curved folds and flutes of semi-transparent pink ceramic material.

The others laid their objects in the baking tray themselves, as the objects were soft. Another woman medical student had made 'my patient's rheumatoid hand' (Figure 73) which she laid in the tray. Collaboration Cluster, a research group at Wimbledon College of Art, worked on collaboration by artists in multidisciplinary settings, looked at some of these *bocca* dealing with the body, including the provocative object, and discussed whether the art object or process of making were important. We concluded both. It is similar for medicine. The object, the operative site is as important as the process of achieving it, with the patient and the team. This is where the empathy is woven in.



Figure 66. They quickly and efficiently filled in their consent forms before they left



Figure 67. A medical student photographs the *bocca* including his scallop shell



Figure 68. *Big Draw* (2009) Medical students make mythical beasts



Figure 69. Pegasus, bronzed (as requested by the student) and her colleague's elephant



Figure 70. Tim the Chef brings the *bocca* from the kitchens for me to check the quality

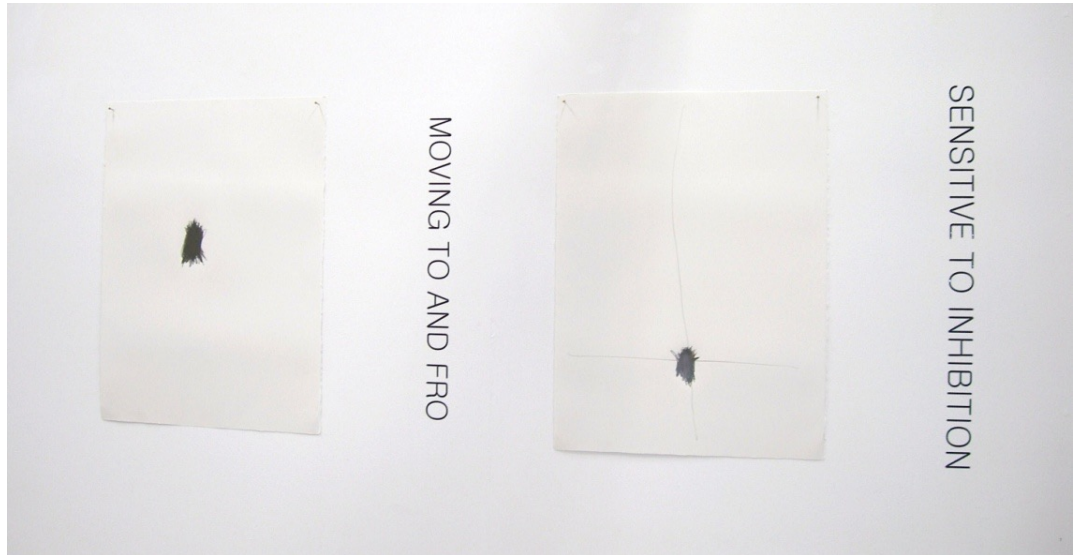


Figure 71. *Sensitive to inhibition* (2009) graphite drawings by Angela Hodgson-Teall shown at Wimbledon College of Art (200 x 84 cm) and Elixir Gallery (below) at QEH

I moved 'to-and-fro', between the hospital exhibition and a group show at Wimbledon College of Art, where my minimal graphite drawings were exhibited. The latter exhibition included drawings by Avis Newman, the artist Sonia Boyce and PhD students from the Drawing Research Centre. Two vertical texts in black vinyl, '*moving to and fro*' and '*sensitive to inhibition*', were displayed in both exhibitions.



Figure 72. *Elixir* Gallery, QEH and Nic, Consultant Haematologist, biking to Pathology

The wall text '*moving to and fro*' referred not only to the movement of the artist between the hospital and the art school but also to the transfer of the staff and patients back and forth in the three hospitals of the new South London Healthcare Trust. The text gave voice to the inhibitory and disruptive experience of the merger. Within the context of the exhibition it also resonated with the ease of inhibition of empathic practice in environments where there is fear and confusion. Psychoanalyst Anna Aragno (2008a) described empathy as a subjective listening stance expressing many qualities, running to-and-fro between individuals in a variety of contexts.



Figure 73. Rheumatoid hand by QEH medical student shown at Wimbledon College of Art (2010)

Another participant from *Big Draw* 2009 said 'empathy to me is the ability to feel what someone else is feeling, alongside them. Really hard - and hard to convey it to them in a beneficial way, especially when you haven't been through what they're going through'. This is consistent with what Wispé (1986) says about the importance of moving between meanings. Making that tiny rheumatoid hand may have helped the medical student maker to imagine and understand a little more how the disease must feel to a patient, as she shaped each swollen, loose and deformed joint.

***Recapturing Empathy* presentation and event (2010)**

The event was preceded by a clinical and art presentation to staff, as in previous years. I presented the case of a patient who suffered from cryptococcal (fungal) meningitis followed by a summary of my collaborative art practice to date.

There were interesting questions about the relative merits of empathy and sympathy and when each one should be used. My answer was that it depended upon individual circumstances and that one should rely upon one's thoughts and feelings (and training) to navigate the territory between them. A guiding principle should be: do I have the understanding (and, in some cases, the time² and opportunity³) to feel the pain and emotions of the other (empathy) or would I be better to limit myself to feeling a supportive emotion for the other's feelings and pity for their pain (sympathy)? A Greek psychiatry trainee offered the insight that empathy should be translated as 'inside passion'. Another Greek psychiatry trainee has since said that, in her view, the phrase 'inside suffering' captures it better. Passion and suffering are the same word in Greek: pathos.

A cat called Francesca, *Big Draw IV* (October 2010)

By 2010 the events had developed a certain momentum. I offered my interventions as a steadying device. The new chief executive (CEO), Chris, appointed to take us through the merger when senior managerial changes were taking place, was willing to join in the experiment. The arts manager and I were in discussion with him and he was in favour of using arts activities and events to facilitate change and improve morale.



Figure 74. Big Draw (2010) Chris, CEO, makes *bocca* with Jeanie, Arts Manager

² The briefest expression of empathy I came across during my research in the Trust was performed by one of our Chaplains who had seen an afro Caribbean woman who had lost a baby. She appeared unexpectedly at his door when he was very busy and he spoke to her for thirty seconds. He received a text shortly afterwards thanking him for feeling her pain.

³ The Chaplains told me about a situation which occurred in a ward bay around the time of the first Big Draw, in which a woman had been diagnosed with cancer. The nurses were very busy and had not had time to talk to the woman in depth. Another patient took this role upon herself and seemed to help the first patient.



Figure 75. *Big Draw* (2010) Chris, CEO makes *bocca* cat. Bike helmet ready for him to cycle off to the next meeting

Francesca was made at the beginning of a day that was marked by its lack of boundary between my practices as artist & clinician. My work was predicated on the oscillations across these boundaries. It was early in the morning and the first participant was Chris, CEO, who was also an experienced doctor. He was travelling between two important meetings and was dressed in his cycle gear, ready to cycle to another hospital site for the next meeting. He had precisely ten minutes.



Figure 76. *Big Draw* (2010) Chris, CEO, and Francesca the cat emerging

The tables, pencils, pens, clay, coloured papers for the event, which I set up earlier, and the arts manager and her assistant were there. He was about to sit down at the trestle table. He was already absent-mindedly rolling a small piece of ceramic clay when I arrived and we (me, the arts manager and her assistant) talked to him about making an animal. He re-started rolling, concentrating on what was being made: a fat sausage for the body and a ball for the head. Small triangular ears were carefully applied. The concentration was intense, focused.

He applied a tiny ball of clay for a nose, whiskers were added, tiny thin strings of clay that had been carefully but quickly rolled. When he had finished Jeanie, the Arts Manager asked if the cat had a name. He replied, 'Francesca'. He said that his son was good at art and had done a drawing of Francesca which was 'a perfect likeness, especially the face'. He described it so clearly that I can still imagine the black and white drawing of a tabby cat. He talked rapidly about artistic talent. He considered that his son had it, but he did not, nor did his wife. So where had his son's talent come from? He stopped for a moment, adding that his grandfather had been a good carpenter and his grandmother a talented seamstress.



Figure 77. Francesca the cat in triplicate, two bronzed (2 x 4 x 2 cm)

I gave him a consent form to complete and as he was writing I started making sounds on the cello; a random sequence of notes. 'That would have helped', he said, answering the question about the impact of the cello on the process of making, before I asked. He viewed the act of drawing and making *bocca*, and the work of the Arts Programme as an integral part of the Trust. He allowed me to show a photograph of him making Francesca the cat, alongside the original and two bronzed versions, at an exhibition of my PhD work in the hospital gallery the following year. This gesture of support consolidated our position and was vital in quelling occasional opposition from other senior staff.

At the end of a run of difficult Consultants' committee meetings over the summer of 2010, when reporting back light-heartedly, on my events, I had described the act of drawing as a useful combination of reflecting, analysing, slowing down and playing. The CEO said, that drawing was 'very serious', and added that that 'applications for this year's Clinical Excellence Awards should come with a drawing attached'. He knew that creative activities were team-building exercises.

Evidence of deeper engagement within the Trusts: *Cleanse* 2010

This year, the *Big Draw* took place during Infection Control Week and I was invited to collaborate with the Infection Prevention Team (of which I was a member in my capacity as consultant Microbiologist) in the running of the *Cleanse* 2010 event, a reiteration and expansion of the original *Cleanse* event ten years earlier, described in Chapter Four.



**Figure 78. Director of Infection Prevention and Control, after completing
Double Blind Drawing**

Staff participating in the corridor event, just along from the hospital gallery, were invited to cleanse their hands with fluorescent alcohol gel and then view them under ultra-violet light in order to see the uncleansed areas in which bacteria might lurk.



Figure 79. Infection Prevention assistant monitoring hand cleansing whilst making *bocca*

The inclusion of *Cleanse 2010*, as an alternative to more traditional drawing practice, was consistent with the position I had adopted as an artist, that there was no artificial separation between art and life.



Figure 80. Infection Prevention Assistant monitoring hand cleansing



Figure 81. John, consultant gynaecologist, stops off to make *bocca* on his way back

I added the use of the cello to bring rhythm and poetic cohesion to the event. The sound of the instrument resonated along the corridors, long slow notes C, G, D, A, played in an order chosen to complement the pitch of the chatter, sound of a bed or the lighter sound of a concealment trolley that happened to be passing along the corridor.

I found that the *Big Draw* events were becoming a topic of conversation and were possibly improving management. Participants working with their team said 'it was fun to see the artistic potential of colleagues' and noted 'discovering the artistic skills of my colleagues'. One of my colleagues told me how my visual art was highly thought of, for example, he had been told about the project by a foundation doctor who had drawn and played the cello for me in *Big Draw* (2008) noting the rhythm of what was going on.

Reflections

Art is useful here because it keeps 'moments of subjectivity' together. Bourriaud (1998, p 91) referred to the way that art contains the energy produced by the 'to-and-fro' engagement of the individuals in society. In this project art may have helped to alleviate anxieties produced by the constant need to deal with the pain, distress and life and death situations that are a regular feature of the culture of medicine. It may have liberated anxieties as will be seen below in the written notes of viewers who responded to the hospital exhibition (April-June 2011) of works made during this *Big Draw* 2010

Drawing shifted the rhythms and responses of the staff, taking them beyond their own expectations by providing an alternative educational route to follow - one that they were able to authenticate. This had the effect of grounding and focusing them.

Drawing bi-manually, double-blind: a further examination

Sitting or lying, the act of drawing blind, bimanually and from memory, the photograph of an animal is a form of 'mirroring'. When lying down the head is in contact with the ground; a vulnerable position, similar to the pose of a patient or sun-bather on the beach. The participants were aware that they had pushed the experiment to its limits and had enjoyed the experience and their sense of being part of it was strong. Some of the characteristics

described by Paula Heimann (1950) in the introduction emerged in this middle phase. Using an evenly suspended attention to follow free associations between the activity and the corridor space, listening to the mind and body on many levels, allowed the participant freedom to respond.



Figure 82. Big Draw (2010) Georgie, Hospital Chaplain, indulges in a spot of double-blind drawing

Georgie, hospital chaplain, who lay down said 'I liked lying down for a moment's relaxation. I was surprised by the beauty of my 'right-hand' image and by the power of my 'left-hand' image'. She had sat to do this exercise in 2008 and in 2010 was now in a position to experiment further and she lay down in my advanced drawing area, behind a newly-washed sheet (with relief, as it was 3pm in the afternoon). After participating she talked about the changes in the organisation, their negative and positive aspects and how it was necessary to nudge things in a positive direction. She commented on different possibilities that might emerge for her and imagined how she might think or feel in the place of others (Batson, 2009).

I had a hunch that this approach would enable me to explore empathy in the difficult and vulnerable situation of lying on the floor in a hospital corridor. Several staff were delighted with the option to lie down in 2010, compared with a relative reluctance in 2007 and 2008, when staff repeatedly expressed the opinion that management would 'not like the idea of

them participating' in the Big Draw. This was never voiced in 2010. There was restlessness in the Trust, a desire to change and move on.

The final note from a participant leads me on to the question of the balance between the two sides of the brain and the two hands. A 2008 participant said, 'The dominant side in the first drawing clearly took the lead. In the second drawing, it felt as though the less-dominant side was to the fore'. These comments are interesting and suggest an awareness of the quality and emphasis of concentration and the idea that there was a shift between the dominant and non-dominant sides of the brain.

Ian McGilchrist's book *The Master and his Emissary The Divided Brain and the Making of the Western World* (2009) explains that during moment to moment activity the brain usually uses whichever side, dominant or not, is better to do the whole job. He goes on to say that sometimes the 'wrong hemisphere does get in first' and the disadvantage of that is that the 'time costs of sharing or transferring control are greater than the costs of continuing with the current relationship.' (McGilchrist, 2009, p 10). My participant thought he had made a transfer, from one side of his brain to the other.

These relaxed yet focused double blind drawing practices may access what psychoanalyst Paula Heimann (1950) described as the positive use of empathy, using hovering attention, to focus on more than one theme at a time, teasing out the most important points. This facility could have contributed to the therapeutic effects that Lygia Clark (Chapter Three) explored with simple objects - stone, netting or a plastic bag - held in the palm of her hands. She applied these objects to participants' bodies, similar to my practice of the laying of the hands on the abdomen in the examination of the spleen, with therapeutic and aesthetic effect.



Figure 83. Concealment trolley and participant double-blind drawing (2010)



Figure 84. Big Draw (2010) Double blind drawing opposite the handwashing station

One medical student, above, had also attended the lecture. She did not think the event would change her view of empathy, adding that it might for some people but not her. I had covered low levels of empathy associated with autism in the talk (Baron-Cohen, 2001). She discussed this with me in the most sensitive and empathic manner and if her movements, gestures and responses were learned rather than innate, I neither knew nor minded. She alluded to the hardening that has to go on in a doctor's mind, in order to cope with what they have to see. This is one of the main differences from practising as an artist, where one may have to make a choice to face horror through work. With medicine it is an inevitable part of the job.

Cello and the importance of rhythm



Figure 85. Artist reseacher, drawing bow across cello, on the drawing scroll

In 'The Music Instinct: How music works and why we can't do without it' Philip Ball (2010) says that music links our brains in a way that no other activity can and that it promotes group activity. The ability to spot the patterns in the music come from the same place in

our brain as our ability to recognise danger, so that both hemispheres become activated when we hear music.

Rudolf Laban talks about rhythmic drum telepathy which is used in sub-Saharan Africa to communicate between tribes with different languages. He describes how the communication is thought to happen:

...the reception of these drum or tom-tom rhythms is accompanied by a vision of the drummer's movement, and it is this movement, a kind of dance, which is visualised and understood. (Laban, 1960, p 60)

McGilchrist explains this as communication occurring because the listener inhabited the body of the person who drummed and shared his experiences. People fell in with the rhythm of their colleagues, soothed and able to draw more easily.



Figure 86. Ehab, consultant haematologist, sitting beyond cello, double blind drawing



Figure 87. Big Draw (2010) Ehab, Consultant Haematologist, drawing

Impressions from participants

For brevity I formulated the participants' responses addressing my most difficult hypotheses about the effects of rhythm and position into a poetic refrain.

Being more mindful

Lying down for a moment's relaxation,

the beauty of my right-hand

and the power of my left-hand

create very different images.



Figure 88. Collage of two drawings *Recapturing Empathy* (2010) exhibited in Elixir Gallery (2011)

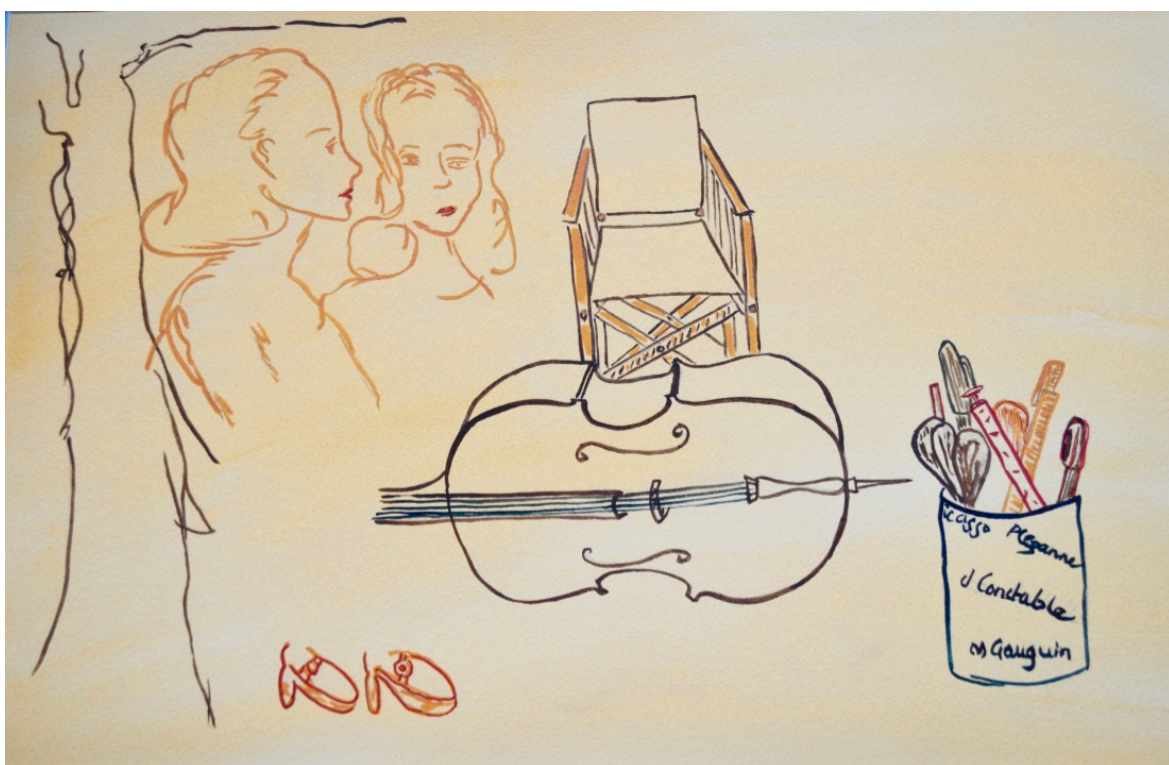


Figure 89. Collage of three drawings *Recapturing Empathy* (2010) exhibited in Elixir Gallery (2011)

The cello clears a space.

It enticed;

The movement of the notes and the pitch

seemed to affect me.

Blindly,

reflecting on past experiences,

it resonated

deeply within my spirit.

Quite amazed.

What thoughts were going through peoples' minds?

I made an hour glass.

It made me smile.

The words of twelve participants were included. I changed the endings of words and eliminated connecting words, using the phrases written on the forms. A similar technique used by Ruth Padel in her book of poetry with words from the notebook of her great grandfather, Charles Darwin (Padel, 2010).

Reflections on Double Blind Drawing in the Middle Phase

One of the problems of the newly merged Trust was that all the rhythms of practice, method and being had been disrupted and new polyphonic practices had not yet emerged. We, the staff, were in a state of transition and transformation. One of the dangerous things about the disrupted situation of the Trust was the sense that neither the managers nor the managed had enough information about each other or the new situation to be able to rebalance and go forward. The artist-researcher (me), Arts Manager, Chief Executive, Medical Director and Directors of Nursing, Research and Education all believed that participation in these events was therapeutic, educational and encouraged cohesion.

It was a porter who was able to play the guitar, helping members of the clinical staff to make a *bocca*, that highlighted the importance of instruments for me. The space cleared by the cello may have allowed room for 'evoked companions', mentioned in Chapter Three in relation to the work of Daniel Stern where, during repeated experiences with the same individual, the memory of the relationship with that individual subtly changed with each subsequent interaction, allowing both people to evolve.

The support for the projects grew during this phase as my practice as an artist and clinician became more integrated. The triple hospital merger generated a sense of loss of meaning in daily life. The Trust was at an embryonic stage and new scenarios were encountered continually. Participants, observers and staff who heard about the project told me that they felt reassured by its presence and encouraged by its aims and visual impact.

Socially Engaged Practice exploring medical student performance

Aim: My Arts for Health careers' eight-week Special Study Module (SSM) enabled the students to bring any clinical performance issues and aspirations to my PhD research project with the aim of grounding and focusing them prior to finals examinations, whilst also improving their craft skills in relation to empathy, gesture and cognition within medicine.

Event Summary

Two of the students who were facing difficulties in medicine, with respect to resilience, found the SSM helpful in allowing them to explore ideas through materials and the mirroring and imaginative practices of empathy. This helped them to modulate their responses to the practicalities of becoming a doctor. These interventions produced a response that had some of the benefits of a one-to-one style therapy by giving the students confidence in their own particular style of performance within theoretical and contextual frameworks.

Case Study 1: Background, Methodological Approach and Outcomes February 2010 (two medical students)

We began by drawing and making *bocca*. Serwa found herself distressed by the sight of patients in theatre. Using the concepts of mirroring, feeling and thinking one's way through empathy, which we discussed in three sessions, she practiced the modelling methods of Rebecca Horn (2005). She wrapped her torso in a plaster bandage to form a cast which she opened and operated on with a surgeon's knife. She created intestines of couscous filled tubing and coloured them with paints, makeup and lipstick.



Figure 90. *Bocca* made by Serwa and Maeve (crown and embryo) before Royal Wedding (2011)



Figure 91. *Bocca* made by Maeve (a bile duct) and *Serwa* (a collection of unmentionable objects)

Maeve draw her patients and talked to them about their experiences. She reported that one of the them found the experience of being drawn helpful in working through what had happened to her. The students felt able to bear witness to the suffering of patients, without feeling excessive personal distress, and thought that drawing had enabled this transition, so that they could gaze without losing a sense of compassion.

During *Serwa's* presentation she revealed that this exercise and the explanation of how empathy worked had enabled her to conquer her fears and move to a position where she saw surgery as a life-saving procedure and was able to empathise with the surgeon as well as the patient, as described by Barbara Hepworth below.



Figure 92. Serwa returns from theatre with *bocca* she made of Orthopaedic cement (for holding hip joint in the pelvis)

In *Drawings from a Sculptor's Landscape* (Bowness, 1966) Barbara Hepworth talked about the clarity of purpose and graceful movement of the surgeon and of the space created by the movement of the bodies, in a series of hospital drawings. Hepworth uses the language that Bleakley and Marshall (2009) used to describe an embodied muscular empathy that the fearful medical student in my Special Study Module (SSM) acquired during the act of recasting her anxiety about the proposed action, showing how both drawing and recasting can both explore and enhance the craft skills of medicine.



Figure 93. Barbara Hepworth's drawing *Scalpel 2* showing embodied muscular empathy (1949)

It became clear that Serwa had mirrored the patient and experienced their distress, making her unable to carry out simple acts in theatre. Having worked this out, we decided that if she empathised with the surgeons, using the act of drawing, this might distract her from the trauma. It worked very well. Serwa produced fine drawings of fellow members of the team, patients and *bocca* from theatre and also became a useful theatre assistant. In turn I found the calm observations of the students reassuring, within the chaotic Trust. A gift had been enhanced and returned.

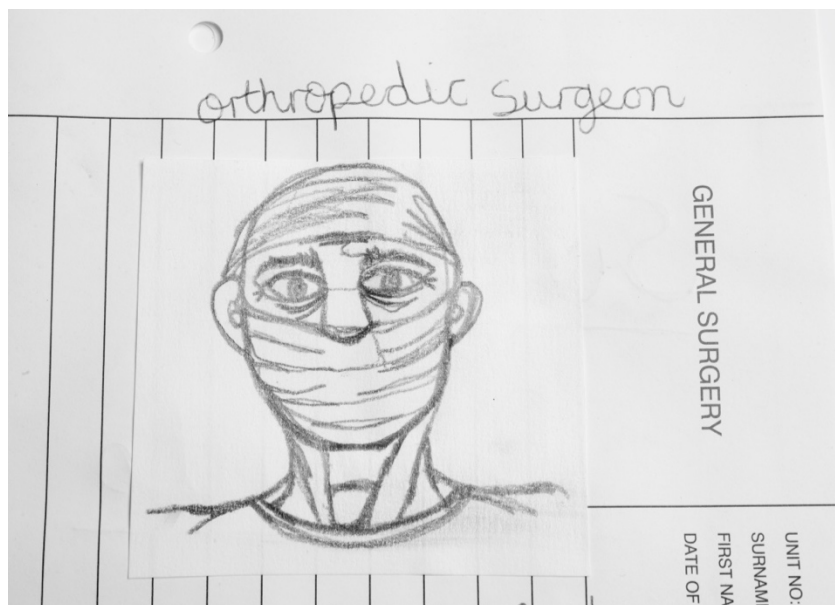


Figure 94 a. Orthopaedic surgeon drawn by Serwa

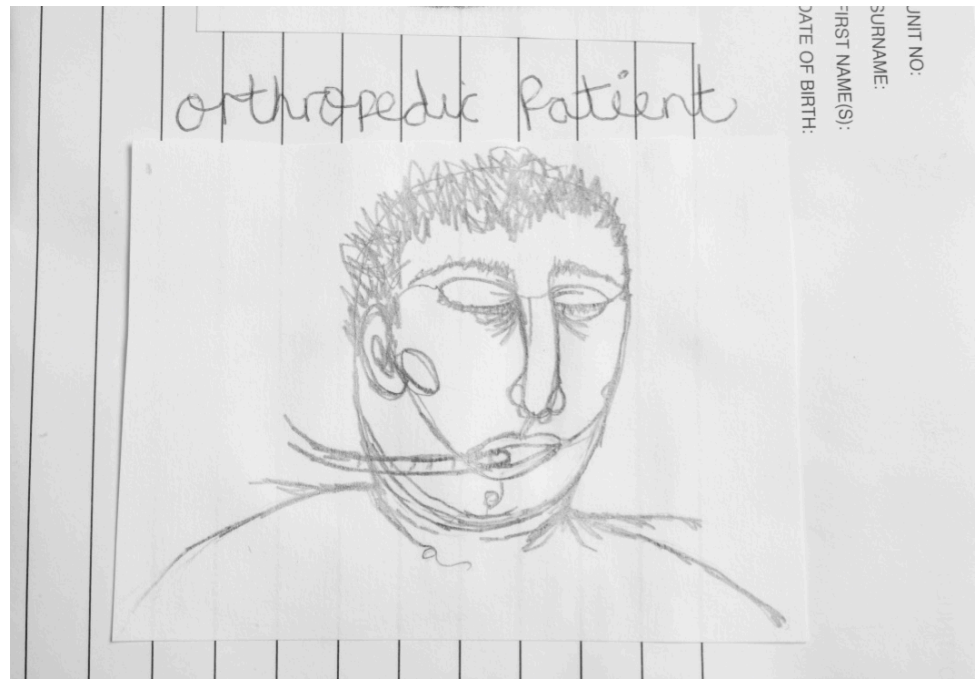


Figure 94 b. Orthopaedic patient drawn by Serwa



Figure 95. An orthopaedic surgeon and his work drawn by Serwa

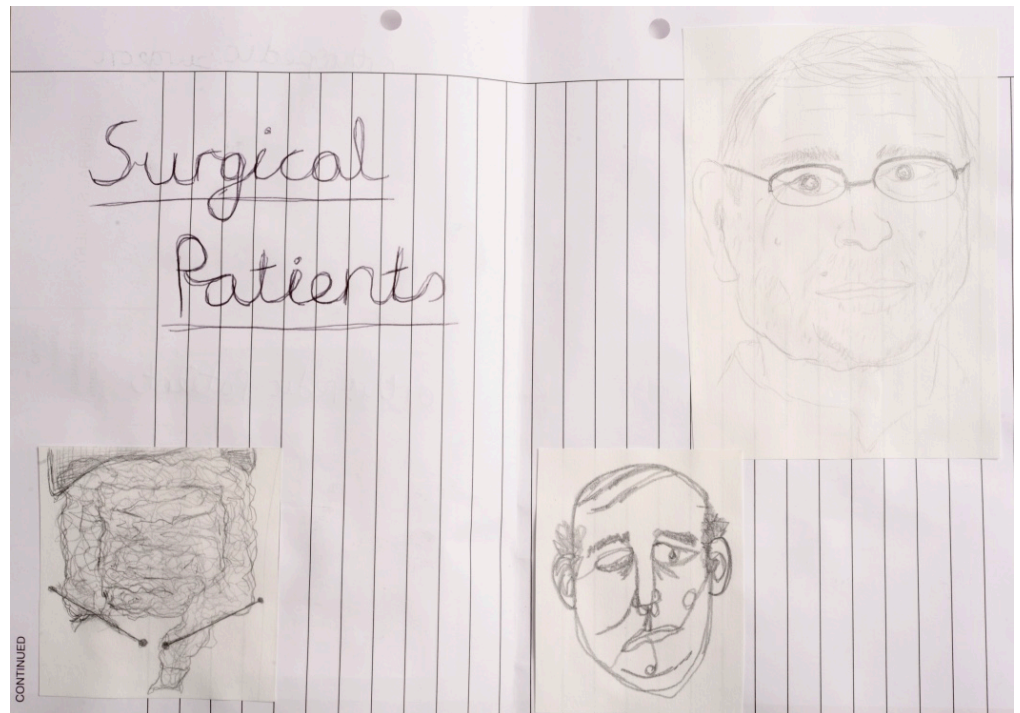


Figure 96. Surgical patients drawn by Serwa



Figure 97. Surgical team drawn by Serwa

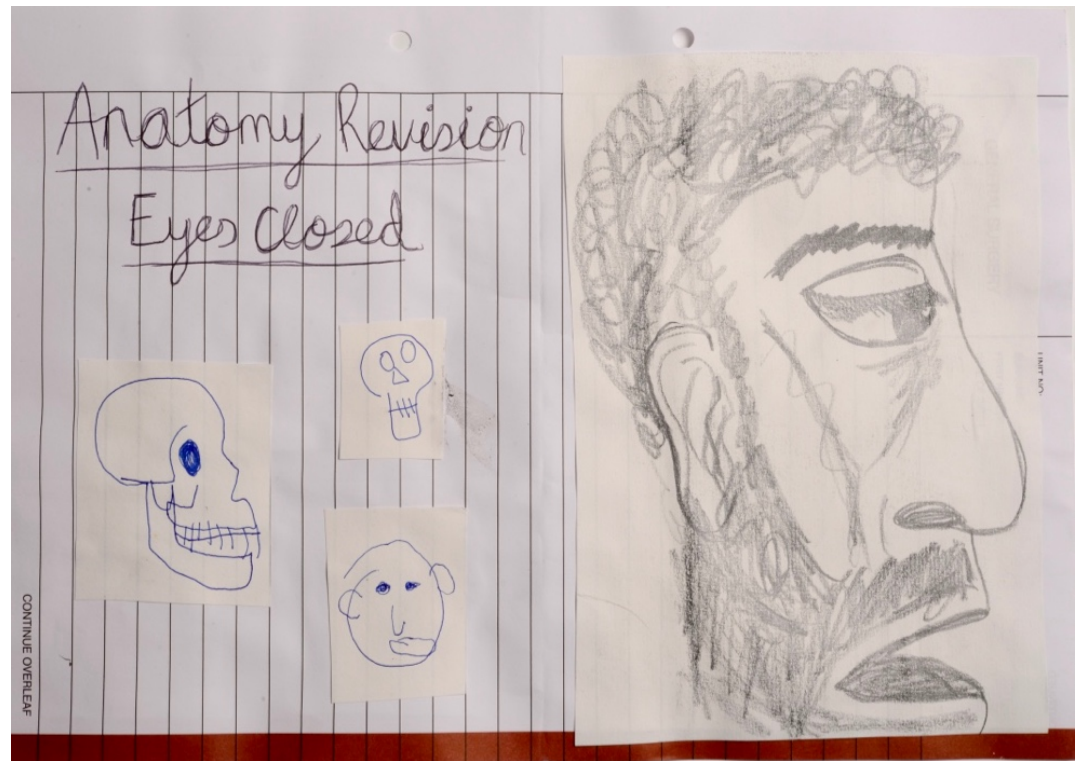


Figure 98. Anatomy revision and orthopaedic surgeon

The orthopaedic surgeons were an ebullient group of multicultural doctors who often argued with one another. They joined in with this project with vivacity and seemed to get as much from it as the student who drew them.

Case Study 2: Background, Methodological Approach and Outcomes for February and March 2011 (three medical students)

The first student wanted to be a breast surgeon, had GCSE art and drew confidently and rapidly engaged with a drawing programme related to his empathic engagement with patients. He later became our cameraman when we decided to take our investigations out into the gallery space and perform them.

Another medical student, Aallya, found it difficult to engage, having not studied art as practice. I encouraged her to work on something she felt comfortable with, such as the yoga she had learned to help her cope with the stress of final examinations and trepidation about becoming a doctor.



Figure 99. Elixir Gallery, QEH (2011): Aallya and Angela practice yoga in the gallery

Aallya told me she had made progress in a brief space of time, improving her body posture and her medical practice by 'developing better body language'.

Josh wanted to be a psychiatrist and he collected stuffed animals. We decided to take our mutual interest in thinking through the being of an animal as far as we dared in the gallery space where staff were used to my performances. Aallya came along too.



Figure 100. Elixir Gallery, QEH (2012): Medical Registrar with Josh's Jay



Figure 101. *Elixir Gallery*, QEH (2012): Aallya, medical student and Angela, artist-doctor



Figure 102. Elixir Gallery, QEH (2012): Angela with stuffed Jay and silk covered hammer

I took the stuffed Jay and stroked it and talked about my memories of dissection of the human body, which I had found particularly difficult as a student. I talked about my horror of the body, whilst sitting on a small round stool with three antelope legs.

Later that day I visited the Haematologists to discuss a patient and was greeted by their registrar. He reported excitedly that the new registrar had returned to the department and said, 'There's a woman in the gallery stroking a stuffed bird'. Nic, the consultant replied, 'Oh, that'll be Angela'. The first registrar, who was well known to me said, 'We didn't know what was going on, but we know it was you!'

The art practice integrated seamlessly into the medical dialogue about a sick patient and talk about dissection of the body. The tension between the two practices appeared to be working productively. The tail end of this case study overlapped with the experiments in socially engaged practice during the *Future is Social* residency. The use of the hammer, covered with flesh-coloured silk chiffon, was inspired by an incident in there, which will be discussed in the next chapter.

Reflections on the Special Study Modules for final year medical students

The two medical student case studies explored collaborative art practice alongside complex issues in medicine. The students found it helped them come to terms with 'acting like a doctor', especially in the presence of the patient for whom one has to feel compassion, not distress. All established a way to work with materials and performance in the hospital in a way that made them more comfortable with themselves and their future practice as doctors. This was not one-to-one or group therapy, but it had some of its characteristics, whilst also being performative drawing in its broadest sense.

Commentary on Chapter Five

This chapter formed a bridge between the pilot phase investigating craft skills in Chapter Four and the final phase where art and medicine held a tense dialogue. There was a repetition of experiments with variations such as: questionnaires about drawing, an expanded practice of lying down, double-blind drawing and thinking through the being of an animal, so that it included mythical creatures and making *bocca* with or without a rumbling cello accompaniment. This resonated with passing waste bins, beds on wheels or the concealment trolley. The addition of hand-cleansing with fluorescent gel and examining the hands under UV light intimated complexity and made the experiments seem more serious and relevant to the healthcare environment. These ethereal touches helped ground and focus the staff during this period of change.

The project became part of the educational process, with managers taking a lead, confident that PhD work from an eminent institution, partly funded by NHS training budgets, gave credibility to the strangeness of events in the hospital.

There was a secondary objective of assessing whether the interventions had any of the therapeutic effects of one-to-one therapy. Participants who had significant opportunity to explore empathy through making and performing, such as the final year medical students, experienced this.

A vibrant sense of living contrasted with themes of sadness and a sense of loss, running through the work. Art practice approached issues of mortality, not only of patients but also of the organisation. By Spring 2011 the tempo and rhythm of research, *Big Draw* events and exhibitions were all established. I had discarded the scientific method (whilst

surreptitiously keeping its bare bones). The consultant body and other staff groups appreciated what I was doing: working with a sense of hope and good humour in spite of adversity, something like a war effort. The unknown fears and aspirations provided a background to the encouragement and support I received from senior management (generous from most though meagre from a few).

The question of grounding and focusing the staff was answered in the drawing exercises: for example, the consultant who drew a uterus upside down for a patient to explain the details of a hysterectomy. The chief executive made *bocca* cats for me and commented how calming the cello was before the next meeting. The work was integrated into the hospital and regularly included lectures and exhibitions. An object was described as provocative by its maker.

Empathy occurred in coming together and exchanging gestures and words, whether actively like the medical students or passively, like Paddy, the Porter who remained on the periphery. This chapter consolidated, enabling me and others to believe in the project.

My participants started to move themselves to a position where the object was helping to do the job of art: grounding, focusing, and challenging the situation in the hospital, growing and developing in response to the Trust's changing status. Their art, with my touches, was exhibited or performed in the galleries at the hospital and art school. These opportunities gave our images and words importance in society and made them available for exchange. On the strength of this work I moved onto the next stage which was to bring art and medicine closer and open up opportunities for a more significant dialogue between them.

Chapter Six: Experimental dialogues between art and medicine

Marry, patience; Or I shall say you are all in all in spleen,

And nothing of a man.

Iago in *Othello*

(Shakespeare, 1604, Act IV, Scene I, L 88)

I am interested in surgery but I am interested in all other aspects of medicine too. Surgery is a very powerful weapon: but it's not a natural thing, so I have my reservations about surgery – because I don't like to cut people, if you like. But it's the shortest way to achieving a major difference to the patients, and that's what attracts me.

Magdi Yacoub, Heart surgeon (cited in *Transplant*, John Wynne and Tim Wainwright, 2011, p 56)

Summary of Chapter Six

The final action research cycle began with my account of a residency programme entitled *The Future is Social* (2011), which investigated collaboration and the gift economy. It sought to create social sculpture and to explore socially engaged practice with the participants. This included taking risks with our art practice in unfamiliar situations and allowing creativity to develop between us, the post-graduate students from University of the Arts London. We were encouraged to experiment. Shifts in practice were made and evaluated and documentation was considered in a critical manner.

I traced the links between the acts of drawing and socially engaged practice in the residency, galleries and departments where I worked. The practice became simpler, more performative, allowing a momentum to develop that addressed hospital staff, who were under more pressure. This made them more responsive to help. I described the events, the objects produced and the performances. Shared insights were gained in both organisations where I worked as an artist, doctor, or both.

The key question in Chapter Six was whether I could entice empathic interactions at the meeting points of contemporary art and medicine, amid hospital disaggregation and contribute to academic debate in both arenas.

This chapter describes events in the hospital and galleries in New York and London. I featured the performances of my alter-ego *Wanda Klenz*, a cleansing sprite who claimed to be 'pure and guilt free'. This was important in allowing me to think through the being of a persona who was not constrained by the rules, regulations and histories of three dozen years on the Medical Register. Wanda does not exist, except in my mind but she was equally ethically bound by the research situation. This helped me to lead the participants of the *Future is Social* in a team cleansing event.

The Final Phase of the investigation (March 2011- December 2014)

This phase unfolded slowly in a way that was sympathetic to the circumstances of the local and national healthcare system. Using my alter-ego, I travelled between art and medicine as Wanda Klenz. I used her to imagine how I would think and feel in another's place. She gave me a freedom that allowed me to bring both practices, medicine and art, together so that I could glide between them. It gave me a way of explaining the complexity to others, keeping me attuned to the clinical situation, whilst also allowing me to maintain distance.

***Wanda Klenz* and the impending disaggregation and reformation of the Trust**

In response to dramatic changes in the Trust, I decided to change tack, take risks, keep my practice minimal and conceptual so that people could play and have fun but not feel too defined by the paradigm 'art'. The Trust mergers had not gone well and there was bad feeling in many departments. Some groups had pulled together but social differences and incompatible approaches took their toll. I thought it was worth putting myself out into the gallery, as an art object that might engender sympathy and shift the emphasis of production from staff to me.

I took part in *Future is Social* residency (2011), did a performance in New York, lying on the floor in Macey's gallery, University of Columbia and hand-cleansing in the *Living and Dying* gallery of the British Museum at Grayson Perry Late (2011 a & b), with the cello as

a simulacrum for the body. Artist collaborators from Thinking Through Drawing re-enacted the humanist wake of Consultant Pathologist, Dr Brew, who taught me as a medical student. Grayson Perry and his alter-egos Claire and the bear Alan Measles (2011a, b & c), helped me to flesh out my own alter-ego *Wanda Klenz*.



Figure 103. Cello on 'Hands On' examination table, *Living and Dying* gallery, British Museum, 2011

This clarified the concepts of drawing and empathy used during art events and gave me confidence that this late work would be taken seriously in the hospital. Staff seemed to have faith in my project.

I gave people time, a word or two, a gesture and in early events, a small piece of clay, which I thrust at them if they looked interested, before giving them space to continue if they wished. Most did.

Residency *Future is Social* in Flat-Time House, Peckham, Spring 2011 and beyond

Aim: In collaboration with other artists in the group and the public; to investigate the social sculpture we created together using dance, song and other gifts; to counter-balance things that went wrong within the group and use the discoveries to feed into the research on empathy in the hospitals, so that a dialogue between art and medicine was firmly established.

Event Summary: The willingness to experiment enticed empathic interactions between members of the subgroups of UAL students from three merging art colleges, Camberwell, Chelsea and Wimbledon. Contemporary art engaged with psychoanalytic techniques and hygienic issues to make social sculpture, contributing to academic debate in the residency.

Cleansing and the removal of dirt and guilt, a symbolic action by individuals on behalf of the community, within the residency, as a performance ritual where the relic of the performance was the bottle of cleanser, confirmed this activity as fundamental to the practice under scrutiny in this research.

Splenic palpation was performed as art practice in a park café after an out-patient appointment. This was followed by other performances of this activity: on the post-graduate artists engaged in social practice at Flat-Time House, on doctors in a hospital corridor and on artists at an exhibition of drawing in New York. This collection of performances established this melancholic activity as important. People found it interesting, amusing and reassuring and liked the firm but assured touch that was required to elicit the spleen.

Background and methodology

Sixteen postgraduate students from University of the Arts, London (fourteen women and two men) joined the programme organised by Sonia Boyce. Gabriela Salgado, a South American curator, facilitated. We investigated collaboration and the gift economy to: create social sculpture, experience socially engaged practice including taking risks with art

practice in unfamiliar situations and allowing creativity to develop. *Shifts* in practice were made and evaluated. Documentation was considered critically.

A series of artist-visitors gave us talks and exercises including singing, curation and copyright. The Tavistock method was investigated during the programmed activities in the second week, with Group Relations support. This method concentrates on the individual, who manifests reactions on behalf of the whole group. It regards the group as a holistic entity that, in some ways, is greater than the sum of its parts. It foregrounds common tasks, functions and motivations of the group, rather than focusing on the distinctions between individuals. As a consequence group-level phenomena that are usually invisible, become distinct (Banet & Hayden, 1977).

The Tavistock Primer talked about such laboratory experiments:

If the Tavistock method often produces data overload and feelings of resentment, engulfment, pain and depersonalisation for the group member, it is because authority, power, responsibility and leadership are difficult issues laden with multiple meanings and bitter memories from the past. (Banet & Hayden, 1977 p 162)

Being immersed in this environment allowed us to examine these areas, the boundaries between and the projections of ourselves and others in a confused and anxious environment. The authors added that 'anything can happen at a (group relations) conference event, and the responsibility for allowing it to happen is shared by all' (Banet & Hayden, 1977 p 165). The two-week group relations conferences at the Tavistock concentrate on group, organisational and social dynamics. They continue to run annually in the UK and also at many locations all over the world.

Dulwich Pavilion Cafe, Dulwich Park, during *The Future is Social* Residency (March 2011).

I visited Dulwich Pavilion Cafe, in Dulwich Park, during *The Future is Social* Research Exercises, organised by Tim Jeeves. I chose an anti-gift exercise and decided to offer sweet-crushing.

I worked with two young women participants, one of whom had just returned from an outpatient appointment at a local hospital. I invited them to crush chocolates wrapped in

silver foil and coloured cellophane. They signed their consent to participate in the research, after hearing my standard verbal explanation.



Figure 104. Dulwich Pavilion 2011: Café participant crushing a sweet

The two young women seemed to enjoy squashing them. The use of 'heavy tools' such as a hammer is normal in surgical medicine, especially orthopaedics. On the strength of this vaguely medical experience I asked whether I could palpate their spleens. They seemed happy to oblige when I explained about the residency *The Future is Social*.



Figure 105 a & b. Dulwich Pavilion (2011): First splenic palpation during the *F/S* residency



Figure 106. Dulwich Pavilion (2011): After splenic palpation

Reflection: The amusement this episode gave us led me to believe that acting out this activity of splenic palpation as performance was worth investigating further. This was the first episode in the dialogue between art and medicine during the residency. It followed on from the squashing of sweets with a hammer, an activity that could have been interpreted as to do with anger, although I was proposing it as a therapeutic medical activity as well as art performance.

Case Study Two: Toilet Cleaning as a team event

Aim: To my surprise the toilet we used in the residency also contained a tiny kitchen area, dust free kitchen shelves laden with spices, kettle and a hot ring, elaborate gothic-style mirror, hand towel and toilet bowl. As a microbiologist I was unhappy about opening the residency's private view with a kitchen inside a toilet, as this contravenes public health recommendations. I aimed to make the environment hygienic as well as an art space, without disrupting the dynamic of the group.

Event Summary

Medicine and art were brought in dialogue with one another, as an hygienic cleaning regime for a toilet was performed as a collaborative art event that was enjoyed by participants at the private view. The cleansing performance brought people together in a

common task that assisted with conflict resolution whilst also providing a dramatic focus for the evening.

Method

The day began with a heated group discussion in Flat-Time House. I declared that I could only participate in the private view if we first cleaned the toilet area. I was caught between the desire to comply with Health and Safety regulations and another reaction, to push the boundaries as an artist. We compromised. I led the cleaning event, with artist and participant Anna Baker during the *Future is Social* private view at the end of the first week, turning it into a group performance.

Outcomes



Figure 107. Flat-Time House (2011): Artists in latex gloves, with cleansing liquid and scrubber

The idea for Team Toilet was part of a desire to resist but it became something else very quickly. The work counter-balanced the disruption that happened during the residency, allowing groups and the public to come together. `Many people in a small space tried to work on something. We cleaned around, under and over each other. It was difficult, claustrophobic but exhilarating.



Figure 108. Flat-Time House (2011): Scott stays in the toilet corner



Figure 109. Tight Squeeze in Team Toilet



Figure 110. Flat-Time House (2011): A participant accidentally pulls the mirror off the toilet wall

As the event was open and announced by a call to everyone to join in, visitors to the evening private view followed us in a small procession from the gallery, across the garden and into the toilet. During the final Team Toilet call (there were three cleaning calls during the evening) we were joined by the majority of the remaining visitors.

A mirror came off the wall during the performance. I spent much of the next week negotiating how to rehang it with a hammer and nail. There were thoughtful discussions about what the events indicated and how we might move forward. The action expressed anger, fear, power and finally repair.

Sonia Boyce, in conversation with Gabriela Salgado, said on the FIS blog: MOVE

'To a large extent, the subject was the people taking part in the residency – the Future-Social collaborators – and I hoped that something could be created and therefore understood about the dynamics of groups and when and how the sculpting of the social takes place. Here, I am thinking of Tino Sehgal, and how when being a part of his work, after a while, when nothing seems to be happening, suddenly something occurs, clicks into place, a situation that is almost imperceptible but is nonetheless there – evident.

The challenge for the residency was to see how and if, as a group, we could pay attention to the 'shifts' that arise when working with other people and use this as the material for making art, to push ourselves to hold what emerges (good experiences and bad) and utilise our creative tools to make those observations apparent'.

Reflections

The extraordinary thing about this type of working is that it was difficult to tell where the idea originated. I came to the conclusion that the combined responses were a product of us all and even if we declined to attend, that absence still had an impact on the others. Guy Brett talks about life strategies in *Out of actions: between performance and the object 1949-1979*

To write about 'live art,' performance, action, participation, surely requires an attentiveness towards the complexity of life itself, its flux, its tendency to exceed systems and dogmas. In a paradoxical way, to write about this subject requires an admission of the particularity of one's viewpoint and knowledge, at the same time as an acceptance of the validity of one's subjective history and lived experience. (Brett, 1998, p 197)

It was not a straightforward set of questions about people making art together because the group dynamics made the processes complex. The art that came out of those encounters belonged to all of us. There was both anger and a desire for repair. We all had the power to wield tools to express this. My subjective history as doctor, microbiologist and artist came into play, in response to the residency, the toilet and the strife, as noted above by Sonia Boyce and Guy Brett. My interest in the practice of empathy brought a therapeutic element to the pragmatic resolution of the conflict. The residency provided a valuable stepping stone to bringing the practices of art and medicine into closer dialogue in the next stage.

***Future is Social* Symposium, Camberwell College of Art 8th April 2011**

Aim: performance of splenic palpation as a therapeutic encounter

In response to the chaotic and possibly dysfunctional behaviour that emerged in the house during the residency (as well as some excellent work and very caring behaviour) I decided to recreate the act of splenic palpation as part of my art practice.

Event Summary: The performance, helped to touch, listen, see, and hear subtle changes in practice, encouraging me to challenge, subvert and question hierarchies, asking the question, 'Who am I looking at and how am I looking at them?'

Method and Outcomes

I set up the participatory activity as an alternative, lying down, activity in one of the rooms where Sonia Boyce's video of dancers, slowed down and moving in time with classical music, was playing, followed by the video *You really had to be there* by Deanna and Sabrina, fellow participants. These were important backgrounds to the activity. I tacked a hand torn piece of thick drawing paper, at door handle level, on the glazed entrance to this room. The following words from Lysander's speech (Shakespeare, 1594) were hand written on the paper:

Brief as the lightning in the collied night,
That, in a spleen, unfolds both heaven and earth
(*A Midsummer Night's Dream*, Act 1, Scene 1)

My participants traced graphite doodles on the scroll of paper I asked them to lie on, in response to palpation of their spleens.



Figure 111. Fiona has splenic palpation¹, whilst drawing to the sounds of videos at Camberwell College of Art, FIS Symposium (2011)

Impression and future development

My first participant was enthusiastic and interested in the thrust of my work in the hospital. She was uninhibited about drawing bimanually whilst having her spleen palpated and it reminded her of examinations she had received whilst in hospital. She had chosen to participate in preference to joining a 'school disco' dancing event. I re-enacted this medical practice as art. A performance that could be returned to hospital.

Lygia Clark (1968) talked about *vivência poética* or lived experiences (Chapter Three). The complex nature of the behaviour of groups revealed itself during the residency. Clark talked about a collective body, an exchange between people of their inner selves. The residency was useful for blurring art and life, using a more experimental strategy than I was able to employ in the ethically bound NHS. This experience enabled me to weave

¹ moving across the abdomen from left to the right, in time with deep inspiration

fact and fiction, rekindle memories and examine the prototype ideas and companions (Stern, 1985) that I and others carried in our heads and brought to life during the residency.

Engaged arts inspired by *Future is Social*, at the hospital Grand Round (May 2011)

Aim: To explore ideas about difficult clinical situations using collaborative practice, as investigated in the *Future is Social* residency.

Event summary: The event was part of the education programme of the hospital. It began with case presentations, followed by a splenic palpation performance and double blind drawing. The lecture brought important clinical issues into focus with a socially engaged arts methodology, passing ideas back and forth between them. Touch and the metaphor of touch were fundamental to the performance that was held in the corridor gallery.

Background and Method

The opening slide was given to me by Peter, a junior doctor who stopped me in the corridor to show me his drawing. In return for my viewing he gave me some clinical revision on splenic palpation.



Figure 112. A Melancholy Nurse digital drawing by junior doctor Peter Summerfield, QEH (2011)

I began the clinical presentation with two complex and emotionally difficult case studies, followed with a visual summary of my PhD arts practice then a collaborative event. The tragic cases spanned a thirty-year period; an infant who died of pneumonia and an older woman who died with infected heart valves and prosthetic joints. The first case was presented on the screen as a short piece of writing or poem.

They witnessed the tragic death of a black child with pneumonia,
drawn on the chest X-Ray.
She had palpated that chest.
The black, African surgeon
who comforted her,
later president of the Royal College
& peer of the realm
(and the white surgeon who,
sometime before, had closed his eyes &
showed her how to palpate a spleen).
The next day he told her not to allow it
to make her give up medicine

The presence and absence of empathy, success and failure within the two cases, was explored. Following the clinical part of the presentation, I invited my colleagues (junior & consultant) to double-blind drawing and bimanual palpation of the spleen in the Elixir *Gallery* where an exhibition of my arts practice was on show. The splenic palpation was not only a medical technique to find an organ that sequestered blood and pathogens, but also my own way of exploring anger and melancholy. Half the audience of forty people came with me.

Performance Outcomes



Figure 113. Elixir Gallery (2011): Sara, Consultant Haematologist, performing splenic palpation



Figure 114. Sara, Consultant Haematologist with A&E doctors

Consultants from Paediatrics, A&E, Palliative care and Haematology supported the idea of the presentation and performance but recommended that I should proceed carefully. It demonstrated empathy both with the patient and the doctor, as well as highlighting the art and science of medicine. I took along a camera and a video so that Portia, a junior doctor in our department, could document this gallery event. Signed consent was obtained, with the standard verbal advice.



Figure 115. Staff double blind drawing at an exhibition of double-blind drawing

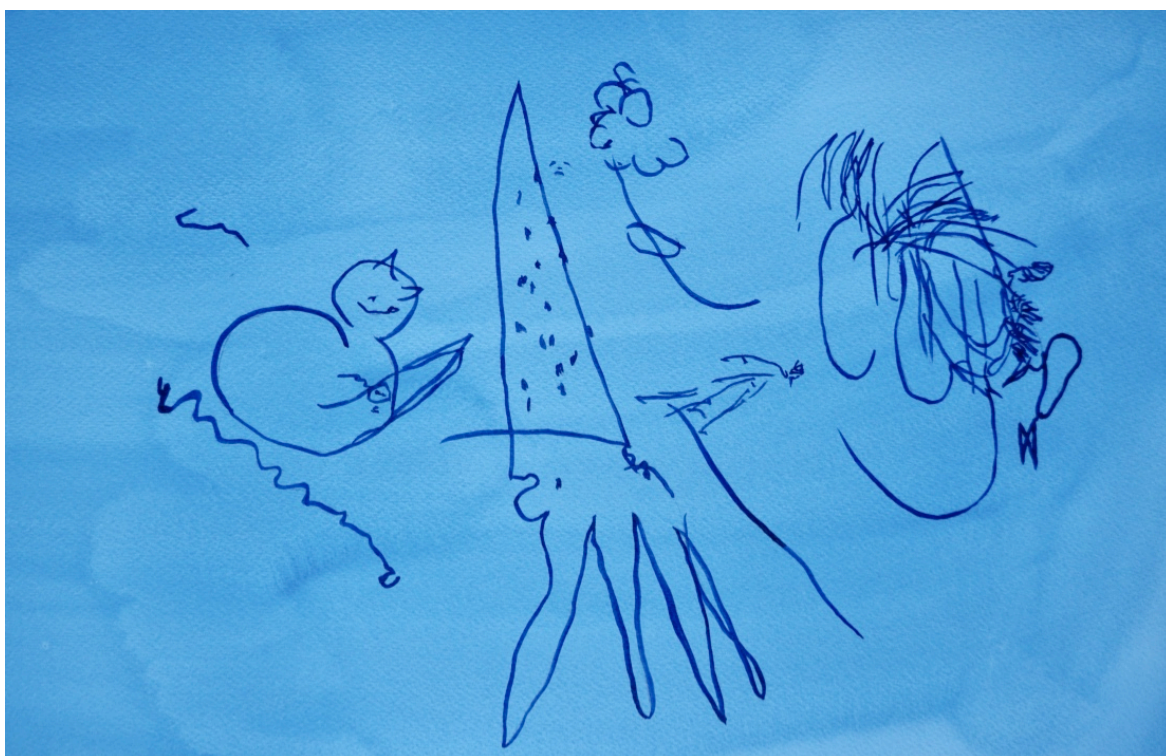


Figure 116. Collage of three animal double blind drawings (dominant hand, traced from 2010)
shown in the exhibition in the background of the event (2011)



Figure 117. Collage of three animal double blind drawings (non-dominant hand, traced from 2010)
shown in the exhibition in the background of the event (2011)



Figure 118. Paediatricians participate



Figure 119. Elixir Gallery (2011) Paediatric team double-blind drawing while a microbiologist videos

The consultant paediatrician, who was determined to attend despite a very busy clinic, explained to me how she tended to cry when telling parents their baby had died and she saw them cry. She was reassured to hear that this was mirroring, a type of automatic empathy. I suggested that by using empathy in a different way, taking a more clinically-mediated feeling and thinking approach (using an evenly hovering attention in order to listen, think and feel on several levels at the same time) she would be able to step back, use a 'gliding' form of identification, enabling her to feel more comfortable with relatives. The consultant brought her whole team with her. They participated in double-blind drawing as a group, embodying their new knowledge.



Figure 120. Elixir Gallery QEH (2011): Foundation doctor from Accident and Emergency drawing an animal with both hands at once

Splenic palpation combined a medical act requiring a firm touch during examination. The person palpating had to kneel or stoop; a humble letting go. The person who was palpated also surrendered. This was an intimate encounter with the other that was pure performance art.

Wanda Klenz Macy Gallery, Columbia University, *Thinking Through Drawing* Conference, New York October 2011.

Aim: To test the practice of double-blind drawing and splenic palpation in an arts gallery in New York, to assess whether it was convincing in a setting where the focus was on drawing. Shakespearian verse in iambic pentameter was used to provide rhythm.

Event Summary: The poetry, the location within a drawing exhibition and the simplified instructions to draw a never-ending figure of eight with each hand, produced a quiet calm in the participants, as in previous splenic palpation situations, whether in an arts or hospital setting.

Method and Outcomes

Wanda Klenz performed during the private view of the exhibition *Thinking Through Drawing*. This gave me the opportunity to check out my findings as most visitors and participants did not know me or the background to my work.

Participants lay flat on a large roll of brown paper in the centre of the gallery while I lay head to head or toe to toe with them. I requested that they draw on the paper with coloured pencil in each hand whilst I recited Lysander's speech about sympathy, heaven, earth and the moment from Shakespeare's *Midsummer Night's Dream* (below). The nine lines of poetry enhanced the rhythmical drawings produced by my participants. I asked permission to palpate my participants' spleens whilst they continued to draw.

Lysander:

Or, if there were a sympathy in choice,
War, death, or sickness did lay siege to it,
Making it momentany² as a sound,
Swift as a shadow, short as any dream,
Brief as the lightning in the collied night,
That, in a spleen, unfolds both heaven and earth;
And ere a man hath power to say "Behold!"
The jaws of darkness do devour it up:
So quick bright things come to confusion.

A Midsummer Night's Dream Act I, Scene I, L 141-149

² Archaic spelling of momentary



Figure 121. Macy's Gallery, Columbia University (2011): Double blind drawing at the private view of the exhibition *Thinking Through Drawing*



Figure 122. Macy's Gallery, Columbia University (2011): Double blind drawing at the private view of the exhibition *Thinking Through Drawing*

Outcomes

Comments from a couple of participants:

‘For me it felt like being transported to a different space. I wasn't aware of this until afterwards but when I finished drawing and opened my eyes I suddenly realised that the room was actually quite crowded and not the quiet, intimate space I had been experiencing with my eyes closed, in which I was aware of the words and the paper and communicating just with you. It also felt therapeutic somehow, although I couldn't describe in what way. There was a sort of trust involved in which I just did what you said without needing an explanation, like in a medical situation, but without feeling vulnerable, just receiving something’ (**participant, artist & teacher**).

‘I felt conscious of rhythm in the movement and sound through the drawing act, which was hypnotic and triggered the same sensory experiences as building a drawing through knitting with hand pins. Because I was lying on top of the paper I felt I was immersed in the drawing both physically and sensually and was creating the drawing from the central core of the paper with pencils as conduits for my own physical presence’ (**participant, textile designer & knitter**).

Using a complex mixture of words and actions I was hoping to continue to examine the ‘*hovering attention*’ aspect of the practice of empathy, as discussed in Chapter Three. The experience could be summarised as an ‘entrance into a trance-like state where one had the feeling that two souls had been briefly knitted together’, which reflects the words used by Hermia, when replying to Lysander.³

By drawing with both hands, at the same time, alongside my participants, I received a dual reflection, an impression from both hemispheres of the brain, which may have made this a rich and possibly ‘real-life’ experience for my participants, in the hospital or gallery, referring as it did to interactions similar to those I made as a junior doctor many years ago.

³ My good Lysander/I swear to thee by Cupid's strongest bow/By his best arrow with the golden head/By the simplicity of Venus' doves/By that which *knitteth* souls and prospers lovers/And by that fire which burned the Carthage queen (Shakespeare, 1594, Act I, Scene I, L.172)

Medicine is an activity that requires constant use of both hands, whether taking blood or examining a patient.

Reflections on Splenic Palpation in four locations

Empathy requires a complex balance of thinking and feeling. Participants told me that having the opportunity to draw resting on the ground allowed more thoughts and feelings to emerge, something I also observed in my research in the hospital. By aiming for an engagement with the physical, searching for internal images and symbols that facilitated transformation, via the process of drawing, I located a space that was both internal and attached to the external world.

In New York, the rhythmical sounds of cello notes, used in previous performances, were replaced with iambic pentameter. Nine lines of Shakespearian poetry talked about war, death and sickness. Participants articulated different aspects of the experience. The act of palpation was not only experienced as touch but was also perceived in a way that might be described as 'knitting' us together.

The practice of public splenic palpation challenged the viewer who was Medical Director of the Trust. The experience was described as intimate, even though it occurred in a crowded room or hospital corridor. It had a quality of being, as if it came from a 'different space'. The medical practice was experienced as performance art. The palpations that were performed in a clinical presentation sparked a discussion about empathy. Automatic mirroring infected some with a sad emotion, in relation to tragic cases. By using imagination, it was possible to interrupt this cycle so that the sadness was not overwhelming. Collaborative art informed medical practice and vice versa, generating interdisciplinary dialogue.

Case studies into Drawing Rituals: Gel Dance by *Wanda Klenz and the Kleening Ladies*

Aim: To examine hand cleansing, one of the most fundamental practices in clinical care, as a joyous and celebratory performance and compare it with Santiago Sierra's *160 cm Line Tattooed on 4 People*, 2000

Event Summary: The following passages compared the gel dance of *Wanda Klenz and the Kleening Ladies* with Sierra's video of the morose, tense and exploitative tattooing of four heroin addicted women prostitutes. The rhythm of the two events was strikingly different. Although both began with a little uncertainty, by the end the *Klenz* participants smiled, joked and mirrored effectively with their hands, as they cleaned them. In contrast Santiago Sierra's group became quiet, anxious or unsteady on their feet. One of the women appeared to express care for others, unlike the men who just measured and photographed. Her efforts were vanquished by the severity of the discomfort, physical or psychological, suffered by one of the other women.

Background: Well established World Health Organization (2009) practices of hand cleansing were used as the basis of the performance which was billed as a 'Hot Case,' with special guest Dr Teall (micro meets art).

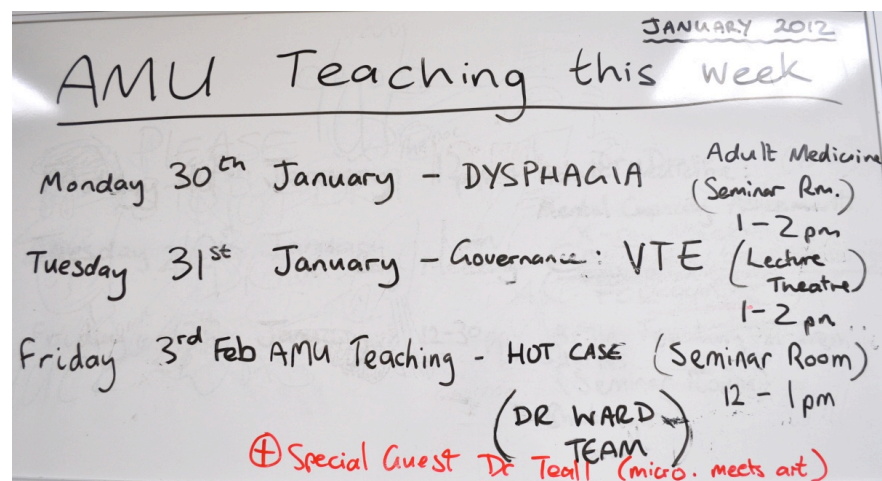


Figure 123. 'Hot Case' with special guest Dr Teall (Microbiology meets art)

Methodology: The introduction of a commentary relating to empathy, rhythm, mango and lemon hand lotion in place of the classic alcohol gel and my alter-ego *Wanda produced* the most comprehensive hand-cleansing performance.

We made *Wanda Klenz and the Kleening Ladies*, a video ostensibly about the process of hand-cleansing, at Queen Elizabeth Hospital in February 2012, in the run up to the announcement that the Trust was to be the first in England to be taken into 'special measures' by the Conservative government (Palmer, 2011).

Outcomes: The *Wanda Klenz* work showed a circle of young doctors, stethoscopes draped round their necks, alongside nurses and consultants, copying the actions of hand cleansing, as if in a disco dance. Nervous laughter broke out as the participants were 'not quite sure what's going on', claimed David, the consultant who was filming. Their reactions ranged from embarrassment through to hilarity.

This work took place in a hospital seminar room where the social network and bonds of allegiance were already formed between the participants. The piece was authored collectively, participants creating roles for themselves. David talked spontaneously to the camera, mimicking a football-style commentary; football being his passion.



Figure 124. Acute Medical Unit, QEH (2012): *Wanda Klenz and the Kleening Ladies*



Figure 125. Acute Medical Unit (AMU), QEH (2012): Debbie, consultant in AMU

By the end, the young doctor who hung back because she did not want to be seen in the video, joined the circle and leant across the field of view, smiling broadly. She took hand lotion from the participant who had charge of the bottle. During the event she lost her shyness and became a full participant in the group. By the end of the third run everyone was thanked for their participation. The artist *Wanda Klenz* led everyone in a round of applause as a celebration of the performance.

A paper scroll of tissues connected the staff as the participants towelled their hands between applications of lotion. Whether this event was interpreted as art was not questioned but the staff were enchanted within the performing space. The bottle functioned as a tool of communication, passing from one participant to the next as they smelled the liquid. The substitution of lemon and mango scented hand lotion for disinfecting alcohol gel, which stings and leaves a sticky residue, made the procedure more sensual. It squirted from the bottle onto the outstretched hands, heightening the empathic engagement between participants. Education and care underlay the dance of *Wanda Klenz and the Kleening Ladies*, with its stream of fragrant lotion and rhythmical empathic gestures.

For *Wanda Klenz* the action may be read as an act of purification in an increasingly mucky health service. A Group Relations Psychotherapist viewed the video and said,

‘Sensuality was present in the touch of the hands. You were also drawing attention to your own poor techniques. There was more laughter than you realised. It was like kids in a playground. Normally doctors are driven by guidelines. It was important here to use intuition as you were taking people out of their normal pattern of behaviour and putting a camera in their hands; asking them to make art with you. Kohut had things to say about this. Mirroring.’

The importance of play was paramount given the high level of responsibility taken by junior doctors. Winnicott (1953) talked about being good enough. The problem is that a doctor has to be more than good enough, so the balance between play & responsibility is necessarily complex.

The work was a spectacle of doctors joining a 'hand-gel disco dance'. The video showed people enjoying being in a group, dancing, taking roles for the camera. The video camera was moved from one side of the room to the other, from a position on top of a chair to hand level shots. In Sierra's piece there is no evidence of spontaneity, the participants are glued to the spot, facing away from the camera until their work is finished.

The artist put herself in the picture as performer. The hand cleansing ritual is an important part of healthcare practice as it reduces the risk of patients and staff acquiring infection from one another. Some of the viewers and participants, who were medically trained, may have had a hunch about an imagined neuroscientific basis relating to the practice of empathy, as gestures were echoed across the room. Using the notion described by John Cage as *Preferring Laughter to Tears*, the activity was useful in work with patients and colleagues, to enhance both empathy and infection prevention.

Mark, a young doctor, who worked in the Department of Microbiology and participated enthusiastically, quizzed me about the tips of my fingers, asking whether I had forgotten them. The tips of the fingers carry organisms and do the most work. The performance used this spectacle as both medical education and art provocation. I talked about correcting mistakes and checked my prepared instructions for other omissions.



Figure 126. Acute Medical Unit, QEH (2012): Mark and the *Kleening Ladies*

My instructions were quite simple: perform the hand cleansing routine, with hand lotion, to the rhythm of '*Staying Alive*' (Bee Gees, 1977)

The roll of tissue, brought by *Wanda Klenz*, for hand drying mimicked the long scroll of paper on which the participants were invited sign their consent. No one objected to signing this blank piece of paper. So much of medicine requires the patient to trust the healthcare worker and participate in unpleasant or scary activities, often with just a verbal agreement. Only intimate and dangerous procedures require written consent.

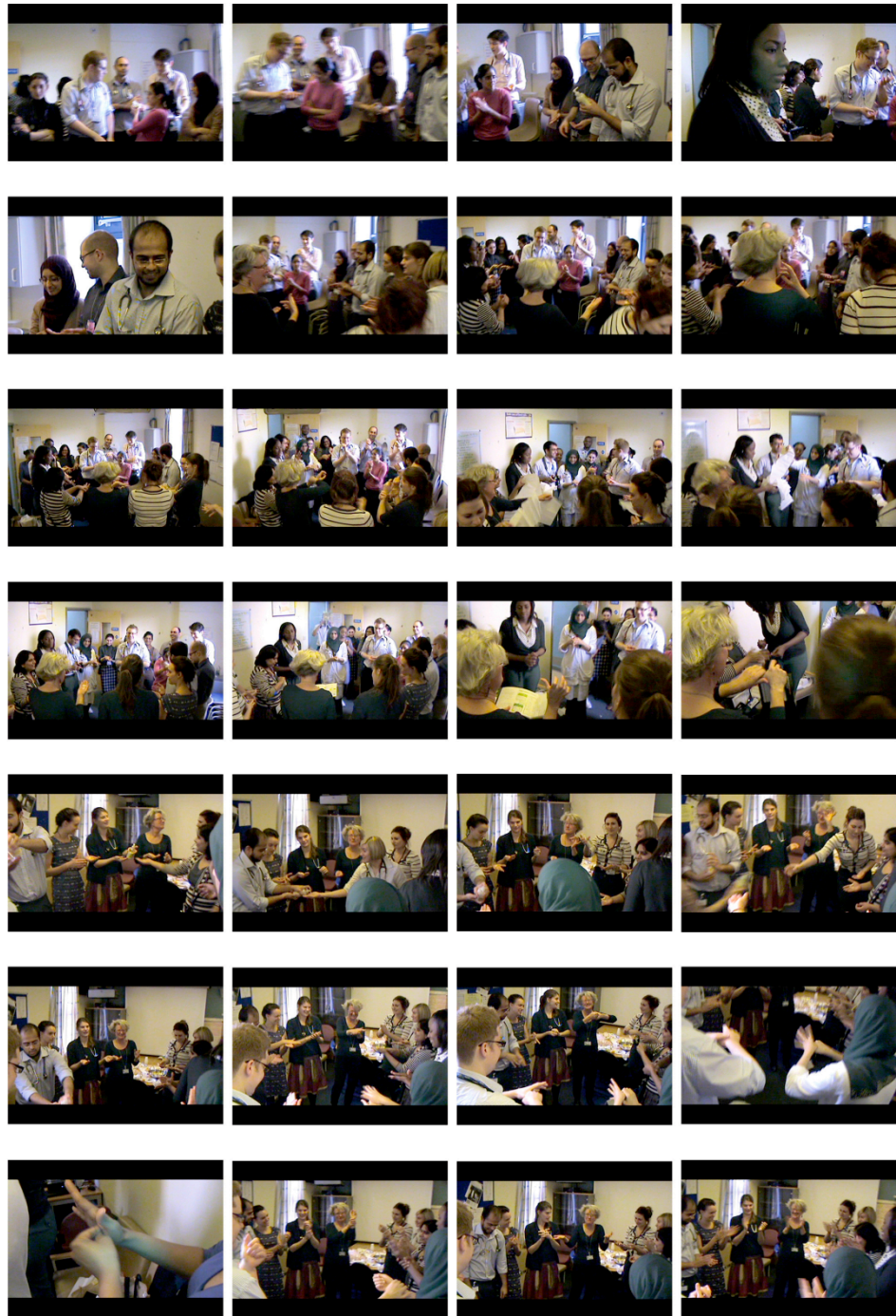


Figure 127. Stills from the video *Wanda Klenz and the Kleening Ladies* (2012)

Reflections on Santiago Sierra

I described the video by Santiago Sierra which contrasted with my work in several ways. He and I shared an interest in the behaviour of people within organisational structures; for him, large corporate groups, making profit, regardless of the cost to others; for me the National Health Service.

Sierra's work was quietly disturbing. I watched heroin addicted prostitutes have a meaningless line tattooed on their backs, in the presence of men, who measure that line, stretching 160 cm across four backs. Sierra displays his large installations in the safety of galleries and institutions that are important in the world of art.

This work (Sierra, 2000) is owned by the Tate Gallery and is described as follows on the website:

Focusing on the extremely poor and disadvantaged, Sierra's works emphasise the tension between the choice of the participants to undertake the tasks for a wage, and their lack of choice owing to their economic situation and neglected medical conditions. The actions he instigates are metaphors – or poetic equivalents – for all the poorly paid jobs backing the structure of the global market economy.



Figure 128. Santiago Sierra, *160 cm Line Tattooed on 4 People* El Gallo Arte Contemporáneo.

Salamanca, Spain, December 2000

The women turned the chairs to face the wall. One by one they sat astride them. Two men entered, swaggering like braggadocios. The tattooist, her hair tied back in a neat pony-tail, wore a red polo-necked T shirt and full-length skirt. She sat down at her chair and arranged the equipment on the trolley. She did not speak to the women but exchanged a few words with the men, who re-appeared, carrying a tape-measure.

The last woman to enter the room appeared anxious. She sat at the far end facing the wall and was still. The tattooist worked deftly and precisely, carefully removing and disposing of her gloves between tattoos. The first woman engaged the third in conversation. Noting the long pony tail dangling over the second woman's wound, the first woman repeatedly swept the hair off her back in an expression of care.

The women began to chat to one another, led by the woman on the left, who seemed to take control by talking and acting. She continued to swivel round, to left and right, to see what was behind her. She leaned across to hold the hand of the third woman, who had become twitchy. The anxious woman at the far right continuously tapped one foot, her knee bobbing up and down. I started to feel concern for her. Cigarettes were smoked, supplied by the man who measured. Precautions were taken: gloves to protect against the transfer of blood borne viruses and regular needle changes. Finally, the women helped the tattooist, holding the paper dressings, as they were attached to the next woman's body, linking one woman to the next in a chain.

Tattooing over, the third woman got up quickly, stepping towards the wall over the back of her chair, in haste to leave without going close to the camera. She walked off without turning round. The fourth woman pulled on her top, turned round to the camera, a cigarette in her mouth. She got up and turned sideways, revealing her thinness. She coughed and wobbled, finishing her cigarette. Watching, I felt her weakness within my body. With two of the four women upset, I realised how little Sierra's scenarios were concerned with feelings of the participants. He drew across women with a line of ink. The procedure was professional but anonymous, a parody of the healthcare environment. A single, static video recorded steadily, set up by an unseen artist.

Adrian Searle said:

His (Sierra's) titles remind us of minimal sculptures of the 1960s and 1970s in their pared-down spareness, their listing of materials and volumes. This is deliberate. For minimalism read materials; for materials read evidence; for action read exploitation; for conditions read economic and cultural conditions; for site-specificity read society; for all of it read capitalism. Such are the terms of the minimalist language and approach Sierra has used since 1990. In a rather literal sense, his work complies with the development of sculpture as prescribed in Rosalind Krauss's essay *Sculpture in an Expanded Field*. (Searle, 2004)

Here Sierra's work is the recorded body, a process controlled by anonymous instructions. There is no evidence of spontaneity. Sierra gave his participants simple instructions: sit and be tattooed.

He was described by the Lisson Gallery (2002a) as asking people to do unpleasant or pointless things for minimal payment. He appears not to care about his workers other than to expose their plight, from which he has material gain, as he is paid by galleries for his work. The arrangements for the workers are made by an intermediary agency who take responsibility for the employment. On occasion he has exposed corrupt practices via this route.

By turning the process of exploitation into a spectacle, viewed in a gallery or museum, Sierra causes the institution to collaborate in relations of power and economics, thus highlighting the ubiquity and inevitability of such relations and raising a number of related ethical questions. By enabling heroin addicts to have more heroin...Sierra himself enters an ethically ambiguous situation in which the artworld participates by purchasing his art product. (Sierra, 2000)

The rhythm in Sierra's work was the progress of the tattooist along the line of the prostitutes, lined up on chairs, as if they were items to purchase or service. *Wanda Klenz* uses an intimate space of care. The Sierra works use a formal or austere arrangement of semi-clothed bodies, emphasising their vulnerable status. Sierra's line up of women, set

against a white wall, is minimal. The shot when the men returned and stood alongside the tattooist, surveying the scene, was composed like a classical tableau.

Both video works refer to society. Sierra initiated actions that intervene directly in everyday life, by undermining structures, to reveal economic and cultural exploitation. Two of the women in Sierra's video appeared distressed physically or mentally, despite the procedural attention to infection prevention. This contrasts with the subject of the *Wanda Klenz* video, where the attention was directed towards engagement of everyone and prevention of infection for all, in an educational and caring manner. There was a desire for equality in her process.

The *Wanda Klenz* imagery, the objects of the lotion bottle and the stream of liquid were used to convey empathy between individuals, as the bottle was passed from one to the other in an act of sharing. In the Sierra video, the gun, its ink held between multiple needles, branded the women with a tattoo.

The pedagogical approaches used in these works are in stark contrast to one another. The *Wanda Klenz* used a dialogic approach, within safe spaces, so that open discussion and diplomacy are central to the process. Sierra's aesthetic approach of Minimalism sets out to expose the selfish behaviour of many in fortunate positions when compared with less-fortunate members of society. Despite their differing approaches the artists engaged because they believed that their work might change the world, either by showing a way forward in the joyful work of *Klenz* or by the shock tactics of Sierra. Both *Klenz* and Sierra tackle difficult ethical areas. Sierra reveals the abuse of women by men, who ultimately do not care for their welfare. Sierra's work attracts controversy and complaint. The *Wanda Klenz* performance was not immune from this. It was cross-disciplinary work in a hospital setting and as Negar Azimi (2011) pointed out in his article on good intentions. Being nice and following strict customs and practices does not necessarily achieve produce change in the world. Empathy and alienation are alternative strategies in socially engaged practice.

Socially Engaged practice with the staff after leaving the Trust

Aim: To return to the Trust as a volunteer who was there to support the staff in a rapidly changing environment, through collaborative art practice in the *Elixir* Gallery, between May 2013 and December 2014, including October 2013 when the new Trust was formed.

Events' summary: This collection of events includes simple gallery interventions with humble tools and familiar activities including; drawing, lying down, sitting and talking, making a Mobius strip. Being there voluntarily seem to make me more approachable. People still talked to me about microbiology and I discussed a malaria audit and accepted an invitation to participate in a Rabies case presentation.

A chair was accidentally broken and turned on its side, when a consensus grew that it was art. It was photographed by several staff. Other activities included a spontaneous sweeping performance by a cleaner, around a fishing net covered in *bocca*.

By the end of the research the following acts by participants in the gallery, were thought of as art: the act of cutting a Mobius loop, rending the seat of a chair in two, crossing the gallery from one side to the other at an important moment as sign of protest, pleasure or submission, the act of speaking to the artist-researcher and finally signing the thesis as an act of support.

Methodology and Outcomes

For each event I used a selection of: sheets of paper from A4 to A2, Fabiano long paper scrolls, Chinese ink, water, brushes, ink grinding stone, tack, watercolour pencils, a fan, scissors and a laptop. I set up 'camp' in the gallery space, creating an installation space for sitting and working or performing with a small folding desk-like table and two director's chairs, so that staff could sit and talk to me or I could answer questions from passers-by. I sat, stood or lay to draw in the gallery on five days during 2013-4. I aimed for therapeutic participation that was small but significant. There was no time for staff to do more in the second and third new Trusts.

Peter, ITU consultant, joined me and sat down comfortably in a director's chair. We talked about deep sea fishing and the Minack theatre, perched on a cliff like an ancient Greek amphitheatre above the cove of Porthcurno in Cornwall.



Figure 133. Peter, ITU Consultant, demonstrating a chair he fell through during the event

Peter suddenly fell through his chair, leaving a beautiful rip in the seat, with a hanging curtain of threads. For the remainder of the day this chair was a source of amusement and play as it took up various positions within the gallery. I claimed it as a performance piece and Peter bemoaned the fact that Duncan the A&E consultant was not there to witness it.



Figure 134. Detail of the chair Peter fell through

Two phlebotomists asked what I was doing and they seemed interested in my explanation so they sat down and one wrote a poem. I talked about being a volunteer rather than a consultant which we agreed, made me much more approachable.



Figure 135. Two phlebotomists (who collect blood), one writing a poem, broken chair in corner

I spotted two ward receptionists standing looking at the broken chair. They were discussing whether it was art or not. One, Debbie, from the Dementia ward, was very adamant that it was. I offered to take her picture with the broken chair. She was not keen but offered to take mine instead with me looking at the torn chair seat. I accepted and posed, trying to look thoughtful. She took three pictures and told me that the last one was the one to use.



Figure 136. The ward receptionist took a photo of the artist/researcher looking at the broken chair

Estates worker Jack talked about retirement and how it was not necessarily good for single people, who might not want to leave the family of the hospital, especially if they lived alone.



Figure 137. Jack (sitting) and Brian from Estates manipulate art-work and comment on life

He then turned the damaged chair on its side and told me it was much more artistic like that. He added that I had been here for long enough and that I should go home in ten minutes' time. As a volunteer, he was prepared to turn over my chair and boss me around.



Figure 138. Broken chair, on its side, exhibited by Jack, from estates

Artist Tino Sehgal (Higgins, 2012) used his prior experiences as a dancer and choreographer to develop personal encounters of ephemeral action with other individuals. Like Sehgal I hoped to produce a '*tableau vivant*' so that those who became involved in my work might behave differently in the hospital as a result of the encounter. My work was joyful, humorous and optimistic and rather than alienating. I was concerned with grounding and focusing individuals, making them feel part of things rather than uncertain about the future.

July 2013, *Mobius Wave Event*, Elixir Gallery, QEH



**Figure 139. Red alabaster egg on inflated plastic bag, after Lygia Clark, exhibited by
artist/researcher**

I sat down and started to make my first Mobius strip from paper, which I split down the middle. I carried on cutting and sticking, this time making the strip broader so that I had a big, fat Mobius strip. I was approached by Aisha, who was short and dark with a mop of Afro hair, grinning at me, looking as if she'd like to join me; so I invited her. She had some specimens in her hand, red-topped and orange-topped tubes, encased in plastic, which she had to deliver to Pathology. 'I'll be back,' she said, disappearing into the laboratory. A few minutes later she returned. I showed her my method then twisted a strip for her and gave her the scissors so she could make a larger loop.



Figure 140. *Elixir Gallery*, QEH (2013): Aisha Mobius Strip maker

She snipped away with great concentration and as the cut joined its origin and the large loop spilled over her arms, her smile spread slowly over her face again. I took her picture, and ask her to sign my blank consent form.

The looping Mobius strip, a reference to the work of Lygia Clark, had provided evidence of its value. Aisha signed my book and left, smiling broadly and twirling her Mobius strip over her arm as she walked away. I photographed the two Mobius strips I had made, sitting side by side, representing the continuous loop of art and medicine in my life.



Figure 141. Two elasticated Mobius strips inspired by Lygia Clark

Our junior doctor from Microbiology, making Mobius strips, whilst discussing a Malaria audit undertaken with David, Acute Medical Unit consultant (and cameraman for the Wanda Klenz video).



Figure 142. Elixir Gallery, QEH (2013) *Mobius Strip* by Junior doctor discussing Malaria audit



Figure 143. Mobius Strip, Infection Control Nurse (and performer in *Wanda Klenz* video)

The simplicity of the Mobius strip was perfect. Anyone could make one. A porter of specimens was delighted with her result. No-one perspired in an effort to 'get it right,' unlike in very early events when staff struggled to make *bocca*. The Mobius strip had a symbolic value, its single side flowing continuously. The gallery became a place for *vivencia poética*, conversation and planning new work.

1st October 2013, the end of SLHT and the first day of the new Lewisham and Greenwich NHS Trust.

Aim: To re-contextualise this time as one of play so that staff at QEH, in limbo between one Trust and the next, could use a dialogue with art to re-engage with healthcare.

I brought the white Mobius strips from July 2013 and *bocca* with fishing nets from the Early Phase of research. The event also functioned as a re-enactment of a contrasting event in October 2012 where the news about the creation of the new Trust was broken to the staff.



Figure 144. Elixir Gallery, Pathologists on first day of new Trust, October 2013

Event Summary: There was an exhilaration and pathos on this day: both a beginning and an ending. The fishing net with its little *bocca* hung from one of the window fittings. The Mobius strips were displayed, curled and waved, alongside a scroll of brown parcel paper. Shells. Crabbing nets and my Director's chair and table provided the gallery furniture.

Some staff from QEH sat with me and told me sad stories; others laughed with me; others tidied my installation for me. New staff arrived from Lewisham offering interest and encouragement.

The socially engaged artist creates meaning through collaboration; I used drawing as my medium. A cleaner asked me to take his picture as he worked around the installation. It was an action initiated by him but it fell within my definitions of telling a story with a simple tool (brush) held in the palm of the hand. The act of cleaning is one of caring for the environment and the people in it and it was an empathic interaction between a health service need and an activity publicised by Joseph Beuys, *Sweeping Up* (1972/85).



Figure 145. Cleaner requests opportunity to clean round objects and be photographed 2013



Figure 146. Mobius strip from 2014 and crabbing nets used in the first event in 2007

Flashing-back one year to October 2012; the draft report about the future of the Trust was written in six weeks during the final exhibition of my PhD work in the *Elixir Gallery* (first exhibited in Cornwall in February 2012, alongside drawings of animals and reflective abstract shapes, by artists associated with UAL). Matthew, the Trust Special Administrator, reviewed all aspects of the service in order to find a way out of our financial difficulties. The report was for wide public consultation and was drawn together with the collaboration of staff at all levels and was announced to the staff on the 29th October, when I did a double-blind drawing performance to mark the event.



Figure 147. Alan, a porter whose trolley featured in my BA show (1997), passes Carolyn Flood's *Angel Eyes* and Angela Brew's *Rabbit Footprint*, Elixir Gallery (October 2012) QEH



Figure 148. Artist-researcher practising double blind drawing October 2013 (and October 2012)

On the 29th my slithering double blind drawing of a never-ending figure of eight across the gallery, timed to coincide with staff streaming past in their lunchbreak to listen to the CEO Chris explaining the future of the Trust: the disaggregation. A couple of people passing were concerned for my welfare, before they realised that I was drawing. Stephen, Director of Research shouted, 'Do you need the resus team, Angela?'

Sally, a member of Chemistry staff joined me on the ground, as staff passed us on the way back to work after the meeting. 'What you're doing is serious isn't it. It isn't just about art is it? It's about hand cleansing techniques and getting it right for patients'. We started toe to toe and moved away from one another on the paper, a metaphor of what the Hospitals within the Trust were going to do.

It felt like the most wonderful fusion of calm acceptance and solid protest. Two or three men walked by and commented, without irony, 'This is art'. The exhibition was popular with staff. The slithering performance was not photographed at the time because of its sensitive nature. The re-enactment of 2013, one year later, is shown.



Figure 149. Elixir Gallery, QEH (2013): Junior doctor explores DBD (2013)



Figure 150. Artist-researcher's double-blind drawing (October 2012) *Elixir* QEH below the Wanda Klenz 'gel dance' photographs



Figure 151. Microbiology registrar and his double blind drawing (October 2013)

Artist observers from the Chelsea MA course at UAL noted that, 'The drawing immediately made me think of an electrocardiogram'. Jane, a viewer and writer observed, 'The act of drawing was anchoring you'.

It was a nod to the life and death situations going on in a hospital. William Anastasi picked up the vibrations from the New York subway when he drew his double-handed drawings as he bumped his way along in a subway carriage in the 1960s (Massara, 2013). I was picking up the vibrations from the QEH cavalcade of staff who passed by me on their way to and from a bone-shaking revelation.

The performance marked a turning point in the Trust's history and confirmed my performances as integral. Staff shifted between a position of anxiety and the recognition that the way forward was for them to release the anxiety. That moment was a confirmation of my role as a socially engaged artist in dialogue with medicine.



Figure 152. IT manager straightens the stones (her suggestion for participation activity) 2013



Figure 153. Duncan A&E Consultant invites the artist to Rabies case Grand Round 2013

Rabies case presentation event summary:

During this event in October 2013, I was invited to participate in a Rabies case presentation, which occurred on the 7th November 2013. My drawings about the patient with Rabies, were made as an act of reflection and re-cooperation following the intense weekend's work. The drawings were made with eyes closed, a pencil in either hand, drawing with both at the same time so that child-like images emerged. My collaborative research enabled the boundary of what is understood as arts practice in a healthcare context to express empathy in a way that encountered, analysed and accepted the medical problem under discussion. Rare cases such as this require wide collaboration between many teams across several institutions.

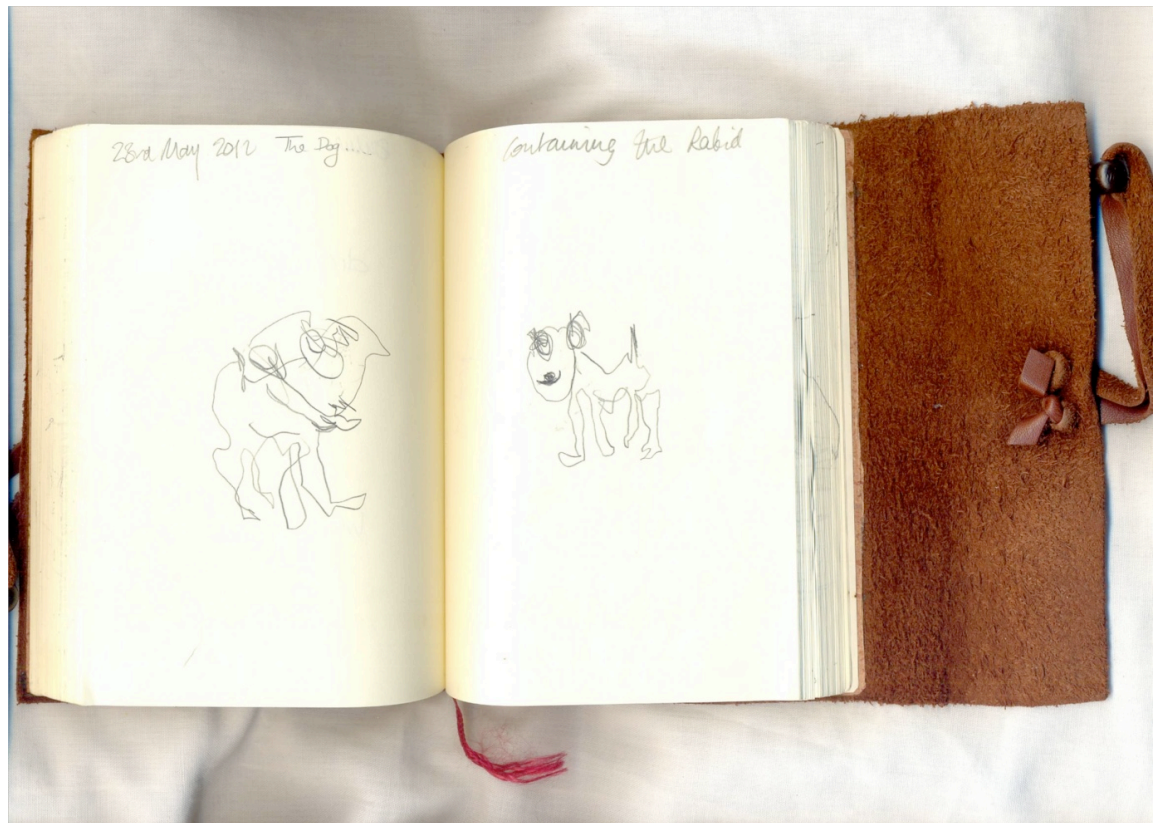


Figure 154. QEH (November, 2013): Rabid dog drawings shown at Grand Round

Martino, consultant microbiologist colleague at QEH, commented that my drawings and comments about the case were the single most important thing I had done during my research. Junior doctors, from many departments spoke to me of how it had 'made them feel as if they were in the room with the patient'. As such it was concise, memorable and valuable as medical education and art and made the point that drawing is a useful visual thinking tool in the practice of empathy.



Figure 155. David, AMU Consultant and Kaenan from Estates (2013)

The following photographs show staff (encountered mainly by chance) from many different departments signing their support for this art project, in the thesis, in December 2014 the month it was submitted for examination. The act of signing your name in the context of a hospital is an important act of taking responsibility, for example, every dose of drug given is signed for. Kaenan responded dramatically to the completed work (Figure 155), which he had been aware of since he first encountered Maeve and Serwa, medical students from the SSM in spring 2010, performing double blind drawing on the floor of the gallery as I played them sounds on the cello.



Figure 156. Kaenan from Estates, performs alongside the cello (December 2014)



Figure 157. Kaenan from Estates, signs his support in the submitted PhD, eighteen months after the event shown in Figure 155.



Figure 158. Nic, Consultant Haematologist and passionate supporter, signs the submitted PhD

Commentary

As a whole, the study helps to make the case that individual observations, reflections and responses represent an engagement with art practice. The presence of the artist in the contested field of mergers and disaggregation led to a situation where the staff and their work place were subtly charged by the acknowledgement of failure of the Trust, a creative expression about the pain, and the desire to escape from it.

The value of artwork was in dealing with a playing out a risky situation, in an experimental way that may have some therapeutic value to the onlookers and participants. I suggest that they mirrored the situation in their minds. They thought about it, maybe firing off a quick comment or gesture or simple acknowledgement. I posited that art practice was a way of encountering the unknown, though child-like processes. The dialogue took the participants beyond a childish (or child-like) way of reacting. The investigation broadened to include a more team and location based approach.

The *Future Is Social* training resulted in a greater confidence with risk taking, using chances, rigorous analysis of found materials and decision making. And the practice of 'not-knowing' (Fisher & Fortnum, 2013) was explored through the research. This is a practice that is difficult to sustain in medicine, where risks have to be carefully quantified before proceeding and thoughtfully managed once identified. Art practice has a valuable contribution to make here.

This research also illustrated that in order to understand the effects of mergers and disaggregation in a holistic way, it was necessary to look beyond the quantifiable aims of the Trust and identify the myriad meanings that can be expressed through art practice. I argued that rather than entering into a decline phase, the playing out of the identity of *Wanda Klenz* produced hope. It cast a glimmer of optimism on the unfortunate dilemmas the hospitals faced.

The project was complicated by a backdrop of public protests and marches against the merger of Lewisham Hospital with Queen Elizabeth, legal campaigns and challenges, judicial hearings and changes in legislature that could have threatened the work. The political situation was challenging. My activities within the hospital were less bizarre than real life. The art events appeared comforting, compared with the turmoil within and around the local Trusts. Chris, the medical director at the time said that:

Medicine takes you back to where you were before, but art takes you somewhere else. Like the Falstaff opera at Glynebourne. That did it. Or Francis Bacon and Lucien Freud in the National Gallery; they do it. And they last forever, unlike medicine'.

The dialogue between medical practice and performance art was a vital part of our collaboration during this period of internal turmoil.

Conclusion

The aim of this cross-disciplinary research was to demonstrate to what extent it was possible to integrate art into the emotional fabric and function of the hospital, in order to improve resilience (by enhancing medical craft skills; grounding and focusing staff) during a sustained period of change; and to question whether art and medicine could benefit from the interface and interaction between them.

The research depended upon the psychoanalytic framework of object relations. Evidence was produced to show that the creativity of participants, who ranged from clinical staff to porters and workers in Estates, was developed. The therapeutic work of Brazilian artist Lygia Clark, collaborations in open spaces by Knížák meshed with music and battle grounds of Jeremy Deller, who all influenced my practice. Staff participants and the Trust changed and grew with me.

This experimental work ran from 2007 to 2014, looking critically at life in medicine, healthcare and art, through the lenses of drawing and empathy. It was carried out in collaboration with staff of hospitals in South East London and arts organisations in London, Cornwall and New York. The thesis began at a point of opportunity and a time of change. An ethical approach to the action research was delineated in relation to the background of medical practice, maximising rather than minimising risks wherever possible, to make the work more exciting for participants and more relevant for viewers.

The work opened with pilot studies aimed at improving the craft skills of medicine (communication, tactile and observational skills), giving participants the opportunity to play with ceramic clay and make a range of objects including flora and fauna, human beings and dice. Drawing was explored with eyes closed using both hands at the same time, often with ground contact, aiming to find out whether such techniques would engage participants during the disorienting period of major NHS reorganisation.

The work moved on to a deeper level within the organisation, involving senior clinicians and managers, exploring their craft skills, making mythical animal *bocca* and engaging career medical students in longer experiments to find out whether they could be grounded, focused and even, through these means, enjoy some of the benefits of one-to-one therapy.

Finally, the research grappled with more difficult experiments of social engagement and found that many staff would push themselves as far as they could in order to participate, extending drawing practice to include joyous hand-cleansing routines, splenic palpation, despite its melancholic references, lying on the ground drawing, enduring public speculation and even enjoying it.

During the course of my research I was employed by the hospital as a consultant medical microbiologist for all but the last year. I had support from senior colleagues to investigate the impact of structured drawing activities, framed as empathic encounters. These happened not only in the gallery, corridors and departments of the hospital, but also in galleries of art institutions such as University of the Arts, London, Columbia University, New York and the British Museum.

In the Introduction, I described my definition of drawing as telling a story with a simple tool held in the palm of the hand, thus emphasising the importance of touch. As the research progressed, the programmed drawing activities shifted from pencil and paper, to making *bocca* (tiny sketches with ceramic clay), drawing with the bow of a cello, cleansing hands coated with lotion and finally, the touch of the hand to palpate a spleen. Empathy, described as an attention, hovering between past, present and future, an awareness of gaps, silences and allusions, was created using these drawing devices. Staff engaged with one another in activities that reflected the stage of the research and the predicament of the Trust, allowing experimentation and risk taking to be pleasurable as well as frightening.

In the first three chapters I undertook literature and contextual reviews in the fields of Medical and Health Humanities, Empathy, Collaboration, Socially Engaged Practice and

Drawing. I discussed the arena of research in which the structured drawing activities were situated. I explored firstly how other artists working in the medical humanities field used their experiences, secondly how researchers and experienced practitioners used empathy in one-to-one and group therapeutic relationships and finally how artists collaborated to make art. Collaboration was chosen as a methodology because it offered a way for artists and participants to explore the difficulties that faced our groups and teams of individuals, in the chaotic, real life situations which were anticipated and encountered. Through empathic processes within artistic events, these problems were distilled, using a drawing as a way of examining them. I demonstrated how the encounters helped staff to make sense of what happened.

In **Chapter One** I described the field of Medical and Health Humanities, which uses art, poetry, music, literature and other humanities to expand the understanding of health (including ethics, yoga and dance) by taking these ways of working to a wider field of practitioners. This approach enabled a broad range of academic and practice-led languages to be used when talking about the body and mind.

I focused on artist Christine Borland, who used mechanical simulated bodies as substitutes for living patients, allowing clinical practitioners a field of experimentation without the risk of harming individuals. Her pioneering work in the field of simulation has explored a range of imagined situations and ethical dilemmas. Her broad practice includes engaging with medical students who talked about their experiences; listening for misunderstandings; videos where the simulation mannequin performed a complex cycle of breathing; stitching of simulation wounds as a participatory activity in a gallery; and recasting a 19th century surgeon's sculpture of a flayed body.

I described the work of theatre director Suzy Willson, whose training programme *Performing Medicine*, for medical students and junior doctors, uses arts and performance methodologies to teach skills that relate to empathy and are essential to clinical practice as a doctor.

In **Chapter Two** I examined the psychological, psychoanalytic and historical background to empathy. I suggested that the act of hovering attentively, as described by Paula Heimann, looking and listening long enough to pick up hidden themes, formed the background to my use of drawing in the practice and understanding of empathy. I described the writings of psychoanalyst and ex-prima ballerina Anna Aragno, whose work on empathy emphasised the importance of gesture and the act of reading behaviour, including that of animals (biosemiotics). The studies of Daniel Stern on infants and children, informed my interest in empathic human encounters and relations with objects.

In **Chapter Three** I explored the concept of empathy through collaborative art practice, referring to the historical background of turbulence against which this work emerged. I considered Hal Foster's important 1996 essay *The artist as ethnographer*, in which he drew attention to the artist's anthropological role, working with others in a way that benefitted society. This approach stems from Marcel Mauss' early 20th century studies of societies that used a system of gift exchange. I discussed how Claire Bishop saw this work moving into the 21st century, in her book *Artificial Hells*, where she delineated a practice that was carefully orchestrated, self-perpetuating and empathic in nature.

I questioned how social forms of art practice involve empathy outside the gallery space, which prepared me for practical experiments in the hospital and informed *Big Draw* events. I noted the aesthetic and therapeutic work of Lygia Clark, using breath and touch in respect to the recumbent body.

In **Chapter Four** I described my action research methodology, which was similar to that used in medical audit. The initial findings generated possibilities for change, which were described, analysed and evaluated. I used a cycle of action research, asking slightly different questions at each revolutionary loop before considering the next step. The investigation was run with the active input of staff participants during each cycle. It was approved by NHS & UAL ethics and research committees.

I went on to address the question of ethical practice within the research, using the medical model, but pushing that as far as possible in the direction of taking risk, (rather than minimising it, as one would do in medicine) in order to enable creative actions and outcomes to take place. My practice addressed the question of whether drawing could be

used as a way of working out how to sustain and augment the craft skills of medicine and explore emotions and thoughts in empathic therapeutic interventions, during the pilot studies. Beginning with simple traditional techniques, such as drawing with pencil and watercolour crayons, we made *bocca* (sketches) with ceramic clay, in the corridor arena. These miniature objects reduced the intimidation that might have been generated by art practice. The invitation to collaborate became irresistible for many, making it easier to introduce more challenging activities in the next stage. The act of lying down to draw (or be drawn around), with both hands at the same time, eyes closed, was introduced.

I showed that the practices of drawing, playing and modelling, created a space which facilitated empathic interactions between staff. Lectures were integrated with these actions, so that there was a solid theoretical and contextual underpinning.

In **Chapter Five** I asked whether drawing could shift the rhythms and responses of the staff by grounding and focusing them, during the early hospital merger. A related question was whether these practices may have engendered some of the benefits of the talking therapies but without actually using this technique on a one-to-one basis.

Explorations with conventional drawing and the *bocca* continued but focused on the idea of thinking through the being of an animal, real or imaginary. I claimed that empathy was coded in scientific and medical languages and linked to a creative space in which collaboration was practiced. Inviting participants to make mythical creatures seemed to be an effective way of encouraging them to engage with clinical issues in an imaginative or risky way. Creative activities became part of team-building exercises.

Evidence of longer term benefits, as might be found in one to one therapy, was sought through a regular and formal engagement with final year medical students on career special study modules in arts practice. The students tried some of the drawing exercises, including making *bocca* in and out of theatre, drawing their patients and performing in the gallery with more challenging drawing tools and approaches. Students improved their approach to the final medical examinations. Acting like an artist allowed them to communicate more effectively with themselves and others, enabling them to act more like doctors. This offered benefit within the medical curriculum.

In **Chapter Six** I explored whether I could entice empathic interactions at the meeting points of contemporary art and medicine, during disaggregation of the three hospitals and a new merger with the fourth. To facilitate this I created an alter-ego, *Wanda Klenz*, who led hand cleansing rituals as performance art. This practice highlighted intimate gestures of touch, without compromising the integrity of those participating. It contributed to debate in both academic arenas.

I contrasted this work with Santiago Sierra's *160 cm Line Tattooed on 4 People* (2000), which was superficially similar to my work. Sierra's interest was in alienation and exploitation, rather than empathy. The *Wanda Klenz* work gave staff another language, using humble tools like bottles of cleansing lotions, allowing them to express themselves in a pleasurable way even though it was slightly scary.

I continued to experiment with the recumbent body, double blind drawing, as a form of protest, acceptance and progress. I repeated the Mobius strip experiments of Lygia Clark. introduced the act of splenic palpation as an art activity, using the palm of my hand to ameliorate sensations, rather than identify disease. The metaphor of the spleen, ancient site of anger and melancholy, encouraged empathy with the sadder, darker side of life in hospital.

As staff, public and political conflict increased, activities became simpler, until the act of walking through the gallery, sitting in one of my chairs and speaking briefly with me, became an act of participation in art practice. I made visible the non-medical support staff from the hospital background, as well as those directly involved in clinical practice.

I led with my practice, as a way of commenting on the hospitals-in-transition during the Late Phase. The new clinical and administrative management team was supportive of my unusual but inclusive approach. I entered the wards and departments, which my privileged position as a clinician allowed and demonstrated that the activities of *Wanda Klenz* coexisted with empathic therapeutic interventions that produced laughter and existed within an envelope of compassion. Mainly, I attended the corridors and enjoyed their rich beat.

I indicated that re-performing *Cleanse* events during the research expanded the field of participation to include staff from all departments of the Trust, including the Infection Prevention Team, of which I was a member. Finally I left the Trust as an artist-doctor and returned as an artist-volunteer, free from a clinical role, dedicated only to the research project.

I made work lying on the ground, slithering as I had done before, but now much freer in my gallery space. I was part of the *performance* of medicine as art (or art as medicine), playing a role in the rhythm and process of change and transition. Exploring gesture through touch; the hand on pencil or clay, the hand on the abdomen and the cleansing hand-on-hand showed an understanding that these ways of touching went beyond the hospital into a wider society. These were the common gestures of art and care.

In order to be less intrusive, in the early stages of the research when I was still unsure how I would be received, I concentrated on traditional forms of art practice. The project was documented with still photographs of events, taken from within the team, by myself or my participants; a form of simple documentation the staff seemed to enjoy and a style which suited my approach. I played notes on the cello to echo the waste bins as they passed through the gallery and down the long wide corridor. It was a way of making the work cohesive and inclusive so that the porters knew they were included too, even though they could not easily stop to talk. In the end, it was for all the people who did not have time to linger. That almost became the point of it.

In *The Future is Social* residency (2011) I encountered similar problems. Both the residency and the Trust included clashes of groups or individuals against a background of institutional merger. I tried to create a world that was almost magical; a social practice making a space of transformation for my colleagues in the hospital and art worlds.

I behaved as if I expected the community to understand what I was doing and accept it with interest and affection, which by and large they did. They joined with my modelling, closed their eyes for my drawing, slithered on the ground on my long scrolls of paper, laughed with and at each other and me. If empathy was an attention hovering with the other, open to interpretation and in dialogue with the meanings of the past, present and

future, then our collaborative efforts in the hospital achieved an empathic practice of remembering and celebrating that was of value to both medicine and art.

The gestures and cognitions that came from a practice influenced by life drawing, as well as drawing from life, were both valuable and therapeutic. When I applied the word drawing to the act of hand cleansing I positioned myself in a clinical arena as well as art practice. Reciting Shakespeare's *Midsummer Night's Dream* (1594) passage about the spleen, heaven and earth and then palpating the spleen of my participants, whilst they lay on the ground drawing with both hands, took viewers and participants into a territory of 'war, death or sickness', a field in which medical practice also takes place. Drawing was embodying the slow rhythm of the process of change.

Art is good at finding things one does not know. I learned how to tap anxiety better. Dissonance was not eliminated; it was lived and worked through. The actions embodied aspirational forces as well as acknowledging the slow pace of change. Both the experiments within the healthcare environment and those within the art establishment showed the importance of a family or team based approach to empathy, as people engaged with one another through the use of processes and the objects made during the experimentation. Drawing was useful as well as entertaining. The staff of the Trust enjoyed taking part in the research and appreciated the opportunity for learning to be shared between institutions.

A significant finding of the seven years of practice was the engagement and acceptance of this complex project, at all levels, from porter to senior Trust manager.

Impact and Significance of the project

There were interesting interstices between the craft practices, tactics of the participants and the senior management team, who wanted to encourage the creative and empathic development of individuals at every level within the organisation. Gathering traces and memories together, in an ephemeral and haunting way, to make objects and performances resonated with most of my colleagues. The action of stitching together cuts from the patterns of art, medicine and life, offered new opportunities and ways of thinking about what had happened.

I suggest that what was important about the work was the sense that I carried the staff with me, encouraging them to change, in preparation for the final phase of the merger. In a sense we became the gallery, allowing the work to create a new syncopation, putting emphasis on weaker beats and highlighting the dysrhythmias of hospital life.

This project attempted to open up and create a space of encounter through touch and the metaphor of touch. The moments of encounter happened within a third space or platform that was not work or play but rather a particular social space in which an encounter with meaning could occur. This required a different way of being in order to retain the heart of the community's social vitality. The work enabled social equality by levelling the status of the participants, creating a culture of coming together and offering psychological support both to the individual and community. This allowed negotiation of meaning, characterised by authenticity with intimacy and dialogue without hierarchy. The work involved a dance in which leadership and followership were passed back and forth, happening at times of crisis, when camaraderie had been built over a period of time. It required patience to find or recognise the moment to apply the 'touch' to open up the space of encounter and nurturing. The photographic evidence from Chapters Four, Five and Six showed people engaged in the craft of making objects, taking up drawing in unusual ways and positions and enjoying it despite the fact that they might look odd. By the middle phase the powerful effect of this work engaged students sufficiently for them to use the work to explore issues around health and identity, touching on areas usually covered by one-to-one therapy.

The thesis demonstrated the high level and quality of participation achieved. The staff felt encouraged and trusted the senior management who allowed these activities to flourish, for the benefit of all. It was important that the study did not jeopardise the posts that people were employed to do. As time progressed the activities were refined and tailored to the complexity of the situation. The practice, including craft and performance activities echoed the position of the patient, often ephemeral and occasionally elegiac but always encouraging staff to join in physically or comment verbally.

The medical students took important steps towards becoming doctors while they slowed

down, played and analysed their practice through the performance of drawing as defined in this thesis. The CEO and Trust Special Administrator incorporated the art practice into their management of change. Involvement of staff at all levels of the Trust was the most fundamental impact of the project, encouraged by the CEO, Chris, who made and displayed ceramic cats, to the sounds of the cello (Figures 74-7, October 2010). He used my arts activities to facilitate change and improve morale (P 144, Chapter Five). Participation was inclusive and facilitated by the CEOs from the beginning. John, CEO in 2007, watched the first empathy drawing scroll unroll (Figures 16 & 17, Chapter Four). Chris and the Director of Infection Prevention and Control used art to disrupt the normal flow of events (Figure 78, Chapter Five). Whether it was the Special Administrator, who weaved a jig with me when I explained my work after the first open meeting (Footnote 4, P 5, Introduction), or a colleague from Estates dancing with my PhD (Figures 156 & 157, Chapter Six), participation was encouraged throughout the organisation.

In some ways this project began with the Turnberg Review (1997) when South London Healthcare Trust and its Private Finance Initiatives were born, sowing the seeds of serious financial challenge (Rivett, 2015). This coincided with viewing Christine Borland's flesh-coloured birthing dolls (P 71, Chapter 3) at the Turner Prize (1997). That year, my surgically hand-stitched, flesh-coloured silk dress was displayed on Alan's Pathology trolley (Figure 147, Chapter Six) at the Christmas Medical Staff Committee, alongside art work from my consultant colleagues. As a result, Richard, CEO, asked me to organise a similar show that would be provided for and by all the staff of the Trust.

In 2012 South London Healthcare Trust hospitals were the first in the country to be taken into 'special measures' (P 194, Chapter Six). This shift in management produced a shift in creative practice. All eyes were on the Trust as we, the staff, lived with the changes. The Director of Medical Education suggested that I could use art practice to encourage a sense of cohesion (P 156, Chapter Five).

A tacit authority from art and medicine, communicated through gesture became available to others (see Figures 68-70, 113-5 and 123-7). Art schools and NHS hospitals faced

similar challenges (P 5, Introduction). Collaborating with practitioners from University of the Arts London, Flat-Time House (*Future is Social Residency*) and Columbia University, New York (*Thinking Through Drawing*) and the British Museum opened a third space in which my research could be extended to new environments (P 171-193, Chapter Six). The 'dangerous' practice of empathy was supported by the Arts Manager and senior staff. Activities such as lying down double-blind drawing and splenic palpation to remove anger and melancholy were accepted at the critical moment when CEO Chris explained the disaggregation of the Trust (P 216, Chapter Six). Stephen, Director of Research, and Sally, from the laboratory staff, joined me on the ground, commenting on resuscitation, the nature of art, hand cleansing and getting it right for patients, identifying actions which may also have been metaphors for the state of the Trust (P 216, Chapter Six). *Cleanse 2010*, a semi-political take on Infection Control Week (P 144, Chapter Five) was a development of *Cleanse* (2000), from our first financial crisis (P 85-7, Chapter 4). This became the dance of *Wanda Klenz and the Kleening Ladies* (Figures 123-127, Chapter Six), months before CEO Chris announced the disaggregation (Figures 147-152, Chapter Six).

CEO Chris stipulated that applications for the consultants' annual Clinical Excellence Award, should be 'accompanied by a drawing' (2010). He knew that creative activities could also be used as team-building exercises and wished to encourage that (P 144, Chapter Five). This action helped validate drawing as a means of expressing thoughts and feelings in the Trust. When Duncan, the Deputy Director of Medical Education invited me to the Rabies case presentation my drawings were used to help communicate the experience of the clinical encounter, enhancing a discussion about empathy in a situation that was frightening for staff and tragic for the patient (P 219, October 2013). The Special Administrator, in his second meeting with consultants made it clear that empathy between staff and for the benefit of patients was essential to his management of change (Winter 2012/3). The new merger had to work for everyone.

The CEOs and Special Administrator realised the potential of the project to bring people together to express their fears and excitement at times of uncertainty (1997-2000 and 2007-2014). The ripples from arts practices spread from the central corridors to touch

people witnessing creative activities. Work focused on the acts of drawing and getting in touch with oneself and others, whether directly as in splenic palpation and drawing a trace from one's own body, or indirectly through the materiality of ceramics, photography or works on paper. Collaboration and empathy were important, especially in the closing year of South London Healthcare Trust (October 2012 to October 2013).

The truly cross-disciplinary nature of the research was experienced at a very senior level as collaboration was between experts in art as well as experts in medicine and health. This introduced the opportunity to play-act about the situation which relieved tension and gave pleasure (Chapter Six). The research at doctoral level had authority, familiarity and authenticity, which enabled CEOs and the Special Administrator to embed it in hospital fabric and function, establishing a space for experimentation.

The catering, portering and estates staff became part of the research as well as the clinical staff – making the project democratic and egalitarian. Stretching the engagement with animals to include mythical creatures helped people to get closer to the mysteries of the clinical process and articulate them through activities such as upside down drawing (the consultant gynaecologist's drawing of a uterus) and the act of naming the *bocca*, as with the 'provocative object'. Making small objects with the bronzed ceramic was playful but the pink flesh colour and texture of the clay linked the participants back to their day-to-day clinical practice. The sight and drone of the cello, as persistent as the buzz of a bee, echoed the body's form and rhythm. It actively occupied or cleared a space that might otherwise have been taken by a person.

My alter-ego, the pure and guilt free *Wanda Klenz* attended to the detail of hand cleansing and the promise of purification. She was amusing, interesting and true to life enough to get people to mirror her activities in one of the fundamental processes of empathy. Whether there is a legacy is yet to be determined. Further studies in other hospitals would help answer that question.

By the end of the research I performed simple activities in the gallery space that seemed to be understood by others, enjoyed as puzzling and accepted as part of a practice that was there to support everyone. This demonstrated scientific methods of medicine working side-by-side with exploratory practices of art. Ideas had passed back and forth freely over the seven years.

This work got to the heart of what a hospital is about by taking an arts methodology which used craft skills as if they would make people better. We used grace, humour and solidarity, taking account of how we felt whilst watching the suffering of others with compassion. The art made the medicine bearable and the medicine gave substance to the art. By sharing the same framework, they both expanded. Participants demonstrated increased flexibility, adaptability and resilience in these experiments. The encounters took place in hospital corridors, departments and galleries, usually in full view of colleagues and public, demonstrating a depth of social engagement that increased the number and range of people who were grounded and focused by the work.

Possibilities for future projects:

I have considered projects that engage with my three research questions in the Chapters on experiments, looking for potential to enhance the practice of empathy in art, medicine and health. The work on splenic palpation, using a close examination of the body and intimate touch, could be expanded to other areas of the body. The rhythm of breathing is already used. Moving up the body to the chest would allow percussion of the lungs between the bony ribs, so that the torso could be used as a resonating instrument, like the cello.

Double blind drawing, coordinating both arms of the body in unison, could lead on to a full neurological examination: for example, reaching out to touch an object, then reaching out again when the object, maybe a hand, had moved, to touch it again. These investigation tools could become both expressive, aesthetic and therapeutic works in their own right.

The ophthalmoscopic examination, using a lens to gaze through the punctum of the pupil to the back wall of the eye reveals arteries flowing like rivers and a moon like optic disc, could lead to descriptions like poems from the body. Turning the gaze back on the body, both physically and metaphorically would open up new ways of thinking about the gestures and cognitions of investigating the body through examination. I have highlighted three small areas of the body to begin an exploration. The examination could extend to the whole body so that many medical investigations could be performed as art practices. The context for this could be a life drawing class, where the metaphor of touch could be introduced in a poetic way to facilitate observation and examination of the body or its simulacrum. Preliminary investigations with fellow UAL artist Miles Coote, in life-drawing performances at universities and London teaching hospitals, including Charing Cross, suggest that such work could attract a wider audience across art and medicine and is worthy of development. There are potential contributions to be made in Special Study Modules, more integrated curricular teaching as well as academic research into collaboration. Many of the centres of excellence in medicine have valuable collections of art work that could be explored with drawing and performance. My own practice as an artist, medical student and junior doctor was inspired, engaged and anchored by the four Cayley Robinson Symbolist murals *Acts of Mercy* (1916-20), painted for the entrance hall of the Middlesex Hospital. They explore the positive forces of the human spirit through the figures of doctors, nurses, patients and orphans during and after the First World War. This maybe somewhere to start.

The anatomy of the deceased patient is currently a taboo area for the artist, relative or living patient. One outcome of this research might be tentative steps towards further examination of the body, in well prepared anatomy departments. Staff, students and relatives would have more time to come to terms with what had happened if they were allowed to engage with the visual and performative nature of anatomical dissection. Drawing with the scalpel through layers of flesh reveals the beauty and complexity of a body that could be examined aesthetically and ethically as well as medically. Medical education and the general public would benefit from a liberal approach to this subject.

Other areas with controversy include the vexed question of whether the field should be called Medical or Health Humanities. I have included both as I began in the field of medicine but as the research progressed in the corridor spaces it became clear that staff in the background were interested and keen to be included. There is work to be done to bridge this gap, beginning with the Association of Medical Humanities and their next conference in 2017.

This work would sit within a socially engaged context, as used by Lygia Clark, extending the anatomical investigations of Christine Borland, recasting the body in a psychological way. This is in keeping with the descriptions of Daniel Stern (1985), where new experiences are incorporated into the old to make minor shifts in the concept of the self in a therapeutic way.

The second area worthy of exploration is the work of *Wanda Klenz and the Kleening Ladies*, where touch and mirroring the hands was used. The hygienic rituals to remove dirt, guilt and purify in an amusing way, express a joy in good, simple performance. Hand cleansing became an art form in the hospital and the idea of hygiene (in this case the prevention of transmission of infection) could be developed further in relation to problematic viruses such as HIV, where one needs to recommend safe sex, or Zika virus (and other viruses or parasites, spread by mosquito, such as yellow fever and malaria) where one needs to avoid the sting of a mosquito. Application of lotion to repel insects would warrant a more explicit dance. The *Wanda Klenz* work with hygiene could be extended to other areas. Working with gender and identity with respect to HIV could be explored through the notion of a protected touch. Prophylaxis and the concept of prevention has potential as well as the possibility of active collaboration with laboratory staff in terms of the culture and sensitivity of micro-organisms. Working with 'the other within' the body is an exciting microbiological metaphor worthy of further exploration in both arenas of practice.

This could be important in the challenging area of antimicrobial resistance which has been highlighted by the World Health Organisation global action plan (2015) and by the UK Chief Medical Officer Professor Dame Sally Davies as vital areas in which to channel

research. The global action plan highlights hygiene and appropriate use of antibiotics for humans and animals. These areas are of interest to me as a doctor and artist. A collaboration could raise awareness and attract other artists with similar interests, who having worked in laboratories, such as Kira O'Reilly to contribute to this arena of research.

Thirdly, I worked with ideas and thinking with animals. *Pets As Therapy* (2015) take dogs into hospitals and homes with therapeutic aims. Here the *bocca* could be introduced so that participants could make a *bocca* dog, benefitting their craft skills and introducing a conversation about art. Finishing with a *Wanda Klenz* hand performance would add to the encounter with the animal. A pilot event with the collaboration of Tressa, a working Cocker Spaniel puppy, Amy McDonnell and Marsha Bradfield at *What Happens to Us* (2016) showed promise. This approach also opens up dialogues about hierarchy, empathy and behaviour which are relevant in many organisations.

The research into empathy, using a broadly defined drawing practice, may be of value to other working communities within the arts, health service and beyond. It stressed the importance of touch and the metaphor of touch, as a way of communicating about empathy, authenticity, experimentation and intimacy. The approaches described may also be of interest to organisations dealing with behaviour or learning difficulties in institutional settings such as schools and universities. There may also be a role in developing empathic leadership, for example in organisations such as Vinci, who provided Estates services to our Trust.

The research occurred against a background of change management which could be of use to other groups going through mergers and institutional upheaval. A package of workshops, performances, lectures and on-going seminars similar to the Special Study Modules noted in Chapter Five could be offered.

Art and medicine can be uncomfortable bed-fellows. The use of hygiene as a theme brings familiarity and a sense of safety, opening up a straight-forward way of promoting thought about difficult situations.

These important emerging techniques and body-centered behaviours encompass both primitive and complex approaches at the heart of what it is to be human. The potential for

creative research into health using arts and humanities has a firm grounding but more advanced creative play could be undertaken in live clinical and management situations in boardrooms, corridors, galleries, wards and departments.

This would give an opportunity to many other artists to work in collaboration with NHS staff, in a way that was initiated by Sonia Boyce's *Future is Social* residency and carried forward collaboratively in the Trusts. This 'messy' methodology is not for everyone. It shakes things up and may have unintended consequences, but it is a powerful tool for change and trust-building, and is worthy of further investigation in other arts and health settings.

The psychoanalytic approaches of Daniel Stern, Paula Heimann and the Tavistock, underpinned the research and gave it political life (Chapters Two and Six). Given its success here, a Leverhulme, Wellcome, Tavistock or NHS funded project, inspired by modern art work from Cayley Robinson (with its images of animals, nursing and medicine), Barbara Hepworth (particularly the hospital drawings) and late modern performance practices of Lygia Clark, would give new understanding of the body's language. Presentation of preliminary work at *Critical Stories*, The Association of Medical Humanities Conference at Keele University (2017), suggested that resistances and reparation could be investigated using such tools and aesthetic experiences. Senior colleagues in crisis situations may be helped by these messy research methods.

Returning to the questions addressed by the thesis my research can be summarised as follows:

The research demonstrated an engagement the craft skills of medicine by encouraging staff to communicate with one another about the objects they made by hand and explore observational and tactile experiences when making *bocca*. These practices grounded and focused the staff at a difficult time. Medical students who were able to spend a regular period of time with me benefitted the most and a couple of them managed to make a transformation in their clinical practice that was quantifiable.

The thesis demonstrated how art and medicine were brought together in close dialogue by this work. Medical practices, such as splenic palpation and hand-cleansing, were explored as art. The art practice was taken out into the corridors of the hospital where it became its life-blood at a time of transition. If empathy is a hovering attention with the other, not obsessed by a single theme but open to interpretation and in dialogue with the meanings of the past, present and future, then our collaborative efforts in the hospital may have achieved an empathic practice that is of value to both medicine and art.

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